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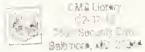
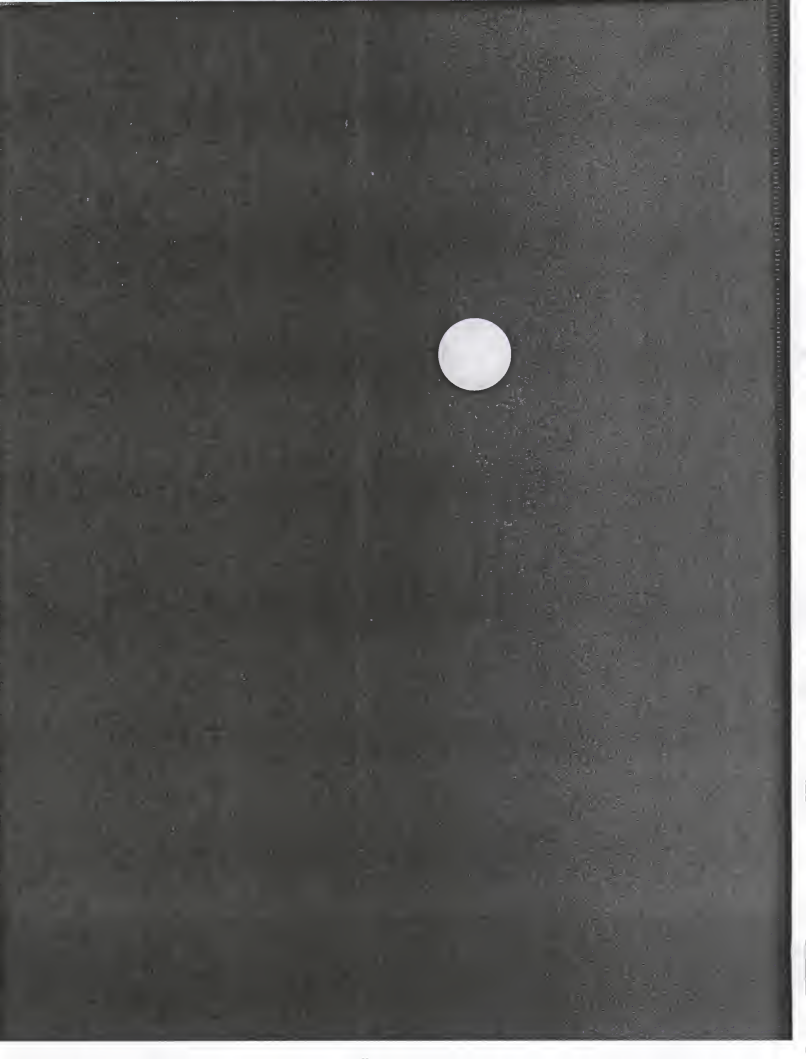
Marketing HMOs to Medicaid Beneficiaries: Evaluation of Alternative Approaches

October 1981



This report is a product of the Prepaid Health Research, Evaluation, and Demonstration (PHRED) Project. PHRED was supported by a grant (No. 96-P-90299/9-02) from the Health Care Financing Administration (HCFA) of the Department of Health and Human Services to the California Department of Health Services. Sidney Trieger was HCFA's Project Officer during the period of work reported here; Trudi Galblum assisted him. The PHRED Project had four directors during its history: James Singer, Rigby Leighton, John Teeter, and Elizabeth Owen. The latter is responsible for the content of this document; authors are identified in the acknowledgments. The views and opinions expressed are the Project's and endorsement by the Department of Health and Human Services is not intended nor should it be inferred.



Abstract

Five methods were demonstrated to inform Medicaid beneficiaries of their health care delivery system choice alternatives during AFDC eligibility determinations in seven California welfare offices. Each method presented the same objective information, comparing the fee-for-service delivery system with local prepaid health plans, through different media: printed brochures, film, and personal presentations by County eligibility workers, health plan representatives, and specially trained State dual-choice workers. Overall, 17 percent of those informed of the choice enrolled in prepaid health plans or health maintenance organizations. Costs per enrollment were lower in all of the welfare office methods than those reported by contractors who were marketing door-to-door. Comprehension of information presented was better for the welfare office methods than for door-to-door solicitation. Demonstrations of marketing through mailing information and choice cards to eligible AFDC beneficiaries and those eligible through State Supplemental Income benefits (elderly, disabled, and blind) were generally unsuccessful. HMO choosers in the Medicaid population resembled those in the literature of white- and blue-collar choosers in a number of characteristics--most notably, lower satisfaction with existing provider, and lack of a current primary care provider.

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Acknowledgements

Making change, like making waves, is not an activity often welcomed in government programs--or anywhere else for that matter. The demonstrations of changes in marketing Medicaid HMO programs chronicled and analyzed in this report were especially stressful to all concerned: the health plans that participated, in full knowledge of the threat they posed to their usual way of doing business; the welfare office management and staffs to whom the implications of the insertion of yet another procedure in an already complicated schedule were quite clear; and to the PHRED staff, all of whom were conscious of the tremendous responsibility that accompanied the opportunity to make a change.

Having acknowledged the stresses of the situation, it is appropriate to credit individuals and organizations for their assistance in overcoming its difficulties. But, first, origin of the concept of the welfare office dual choice should be recognized. An old idea that long had been seen as probably the best all-around solution to the "Medi-Cal marketing problem," it was not an innovation of the Project. In fact, several other states already were offering HMO and prepaid health plan enrollment within their welfare offices and California had tested versions of the concept in a very limited fashion in several offices. What the Project did was to recognize the need for a large-scale test and insist on carrying it out to the point at which results were clear and supportive of a major change in the program in California.

Perhaps it also is appropriate first to acknowledge the financial assistance from the federal government--the Health Care Financing Administration of the Department of Health and Human Services (nee Health, Education, and Welfare). The grant that funded the Membership Studies component of the PHRED demonstrations, of which the marketing projects were the largest part, was generous, allowing a full test of the dual choice concept.

But having money and what money buys--staff and time--were not enough, as we learned early on. We needed and got support from above--from the directors and managers in the State Department of Health Services--Jerome Lackner, M.D., and Beverlee Myers--and their deputies, Bruce Yarwood, Bill McLeod, and, especially, Betsey Lyman. The County Social Services Department administrators were cooperative in giving priority to the demonstrations among the many conflicting demands for their staffs' time and energy.

Now we come to the people who did the work: five field representatives --Anthony Meeks, Tom Buser, Josephine Cobb, Kathy Green, and Bob Peterson--collected the data in the welfare offices--by working and virtually living in them for a year. Within the PHRED offices, the technical support group staff had major roles in the development of the demonstration methods and in the interpretation of the results. Barbara Curbow developed the data collection instruments and oversaw the pretests of the collection procedures; Tom Wilson assisted in the design of the evaluation, supervised the data input to the computer and, during

the analysis phase, almost endlessly pulled data out for us in a myriad of shapes and forms, which he then patiently interpreted until the rest of us learned how to read print-outs right-side up. John Hanretty supervised the field staff and worked with the health plans to get data from their current marketing efforts. He also managed the large group of telephone interviewers and data coders who carried out the comprehension and verification surveys and those who sent referrals to the health plans and kept track of the results of everything. Finally, John helped me write this report--he is responsible for the cost section and provided major assistance in the interpretation of the data in the rest of the results sections.

In the design of the demonstrations, we had invaluable help from Thomas Bice, Ph.D., who served as a consultant to the Project. Our productive relationship with Tom was the direct result of a routine literature review and I suggest its beneficial outcome as an exemplar to all researchers who go through a literature review pro forma. Tom was also of great comfort to me at the end of the demonstrations when he assured me that all such big projects always leave more unanswered questions.

This report was completed after the PHRED Project formally ended. In fact, it was completed after I left state employment. Both of these situations required concessions from current employers of previous PHRED staff and from the Department of Health Services, generally, in supporting the production of the report. Former administrative assistant Kathy Bridges came back at odd hours and helped edit. Virginia Herold, a research analyst who came to the Department after the end of the Project, took a professional and personal interest in helping me complete the details of the analysis. Finally, the professional competence and good will of word processing technicians Maggie Cummins, Pat Holcomb, and Alice Heaney are greatly appreciated--as usual.

To complete the listing of those who made the demonstration and report possible, I want to mention our best and most helpful critics--our project officers in HCFA, Sidney Trieger and his assistant Trudi Galblum. Their patience has been appreciated as much as their comments.

Finally, to recognize my family--and the families of others who worked on this project--how to thank them for giving the time and support that allowed us to indulge this obsession to finish the project and this report? I can only offer Tom Bice's final reassurance to me that "most people only have one of these in their lives."

--Elizabeth W. Owen
Project Director
November 1981

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SUMMARY

Background

In 1976, DHEW and Congress recognized the need for new approaches to rescue the prepaid Medicaid program, then under fire from a variety of quarters. The California Department of Health was awarded a large grant to improve management and monitoring of the Medi-Cal PHP contracts and, while so doing, to develop model systems and methods that could be used in other states. Proposals to DHEW's Health Care Financing Administration were approved for demonstration of Medicaid marketing techniques and quality assurance systems for monitoring HMO Medicaid contracts, and for development of an actuarial approach to Medicaid rate-making. The organization put together to carry out the demonstrations was the Prepaid Health Research, Evaluation, and Demonstration (PHRED) Project.

With the decision of the California Legislature in 1977 to end door-to-door solicitation as soon as an alternative could be found that would support a viable prepaid Medi-Cal program, PHRED was looked to for development of the new method (or methods) that would solve the twin problems of identification of the marketplace and motivation for enrollment. Demonstrations of various dual-choice methods in the welfare office eligibility determination process began in early 1979 and were completed in June 1980.

Demonstration Design

The Project selected the welfare office as the demonstration site because it satisfied the requirements of the three premises of the experiments: (1) that there must be a uniform and universal information-giving and choice-making opportunity in order for a representative cross-section of the population to enroll in prepaid options;

(2) that there must be a motivation for the Medicaid beneficiary to make a choice between and among the options available; and (3) that the choice must be presented objectively and cost-effectively in order to support a credible and viable program. Other than the welfare offices, no setting allowed universal access to the marketplace. The eligibility process was seen as appropriate because it was objective and because its importance to the Medicaid beneficiary would lend authority to the choice-making process.

The PHRED demonstrations were all based on giving the same information (basically an objective presentation of the differences between use of the fee-for-service card and enrollment in a prepaid health plan, plus descriptions of the local plans available), through different media and then requesting a choice. The abilities of both the media and the message to motivate informed choices between the options were tested--in effect, replicating as closely as possible the dual choice situation in which a new employee makes a coverage choice between an HMO and an indemnity plan offered by the employer. The demonstrations were located in seven welfare offices in Northern and Southern California, chosen to represent a variety of possible local environments.

In each welfare office site, information was presented through five methods: a printed brochure, with little or no personal explanation before choice-making; a film, made by an Academy Award-winning Hollywood producer; a personal presentation by a county eligibility worker; a similar presentation by a specially trained member of the Project staff; and a personal presentation by an HMO sales representative. Generally, each method was demonstrated long enough in each site to give data on at least 100 intake encounters.

In order to test another approach, mailings of printed information were sent to all eligible beneficiaries in the geographical areas served by demonstration site welfare offices. Addressees were requested to return

choice cards which allowed enrollment by mail, requested more information from local HMOs, or expressed a preference for the fee-for-service system.

In the third method tested, health plans in the area were asked to supply data for the control on the experiments--costs and results of marketing presentations using their current enrollment presentations and approaches (usually door-to-door solicitation, but sometimes buttonholing people as they came out of welfare and food stamp offices, contacting referrals from existing members, or other methods).

Analysis and Evaluation

The experimental design for the demonstrations allowed comparison of the three major methods, including the current marketing approaches of the HMOs. Evaluation criteria included: The rate of choice of the HMO option versus the fee-for-service card (the penetration rate), cost per enrollment, comprehension of the information presented to the choice-maker (with the assumption that enrollees who understand the meaning of health plan enrollment would be more likely to be satisfied and therefore stay enrolled in the plans longer), and general acceptability. Data were also analyzed for the factors that determined the choice for HMO enrollment and results were compared with the literature of choice-making by other groups.

Results

Illustration 1 shows the results of the welfare office dual-choice methods arrayed by the three quantifiable evaluation criteria. While all methods tested produced enrollments, results reflect the influence of local conditions. The site variable was apparently stronger than the performance of the method in motivating an HMO choice. Penetration rates by site ranged from 9 to 32 percent and were more consistent than

penetration rates by method of presentation (range, 2.3 to 60 percent).

Comparison of costs indicated all of the welfare office methods were cheaper than the mailing. The cost inefficiency of door-to-door solicitation was evident as was the mailing method's low penetration rate, even though the costs per potential contact were low.

Results of a true-false test given after a six-week delay to a sample of beneficiaries from the three major methods showed that HMO choosers generally were better informed about HMOs than those who chose the fee-for-service system. However, the fee-for-service choosers from the door-to-door solicitation group scored higher than those enrolled in an HMO.

Acceptability, the non-quantifiable criterion, was applied to the methods through surveys of those who were affected by the demonstration--chiefly welfare office workers and managers and HMO executive and marketing directors. Predictably, the welfare workers preferred the methods that were least disruptive to their current responsibilities, although they did support the concept of a dual-choice offering. Health plan managers varied in their evaluation of the methods. Those whose plans depend heavily on Medi-Cal enrollment were concerned about how their plans would fare in the welfare office marketplace without the direct control afforded by solicitation. Those who were not marketing directly, or who preferred not to do so, were very supportive of the universal choice at the time of eligibility determination.

Beneficiaries, as a group, were not surveyed for acceptability of the dual choice methods. However, an indication of acceptability comes from their willingness to make a choice: less than half of 1 percent declined or failed to do so in the demonstrations.

Choice Determinants

The Project's intention to produce profiles of beneficiaries likely to choose both systems was frustrated by problems of sampling (the seven offices and the 7,634 beneficiaries who chose between the systems are not necessarily representative of all Medi-Cal beneficiaries in California), by difficulties in following up with samples of choosers, and by lack of comparability among data collected for each major group.

The Project was able to examine several demographic factors and to collect subjective data on reasons advanced for the choice. Indicators of health status, which were assumed to have had an influence on choice, are also reported.

DEMOGRAPHICS

Education--In the PHRED data, the higher the level of education, the greater the likelihood of choosing an HMO.

Age--Unfortunately, age of children was not available consistently in the PHRED data, but the welfare office results indicate that the families were young, since 66 percent of the choosers (usually the parents) were less than 30 years of age. Age distributions for the fee-for-service choosers were almost exactly the same and showed no effect of age on choice.

Number of children--Family size,on the other hand, was a factor associated much more clearly with choice. Those who chose HMOs were more likely to have larger families. The penetration rate for those who had four or five children was 23.1 percent.

Ethnicity--There were significant differences between HMO penetration rates for ethnic groups. Blacks and hispanics were the least likely to choose an HMO (15.2 and 15.9 percent, respectively). Whites, who

constituted the only other sizeable group of choosers, picked HMOs at a rate of 19.4 percent.

Previous Experience--Previous knowledge of the HMO was not shown to be predictive of HMO enrollment (slightly more fee-for-service choosers than HMO enrollees said they had heard of HMOs before); however, previous enrollment in an HMO was a determining factor for an HMO choice.

Health status indicators--Although it was not possible to assess health status clinically, the demonstrations did collect some self-reported indicators of utilization and health status:

- HMO choosers (54 percent) were more likely than fee-for-service choosers (44 percent) to report needing care "now".
- HMO choosers reported fewer visits to the doctor during the year preceding the enrollment decision.
- Hospitalizations were almost equal between the HMO and fee-for-service choosers although slightly more HMO choosers reported no hospitalizations during the previous year.
- HMO choosers were less likely to have a family doctor relationship than fee-for-service choosers.

Of all individuals contacted by the Project, those (90 percent) with a physician relationship reported themselves as either "very satisfied" or "satisfied" with the care they received. However, the overall satisfaction level of the HMO choosers with a doctor was generally lower than that of the fee-for-service group, since fewer HMO choosers reported satisfaction with care (83 percent versus 92 percent) and more HMO choosers reported dissatisfaction (4 percent versus less than 1

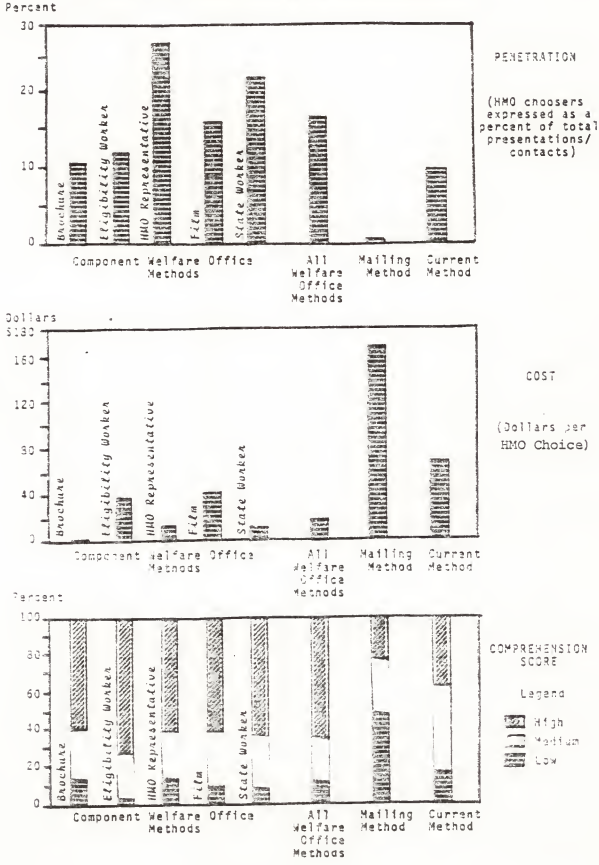
percent). Similar patterns of satisfaction and dissatisfaction with care were found in those who did not have a family physician. A much larger group of the HMO choosers (18 percent) who did not have a physician relationship reported dissatisfaction with care.

ATTITUDES--The perception of the quality of care delivered by the HMOs seemed associated with the type of health care chosen. While 66 percent of those choosing HMO services believed HMO care is better than that delivered by the fee-for-service providers, only 8 percent of the fee-for-service choosers felt similarly. Additionally, less than 4 percent of the HMO choosers, but 52 percent of the fee-for-service choosers, perceived that the quality of medical care is lower in HMOs.

REASONS FOR CHOICES--The main reasons given by HMO choosers for their choice were "more services," "convenient," "try it," "better services," and "enrolled before." The fee-for-service choosers explained their decisions primarily on the basis of an established provider relationship (25 percent), with "freedom of choice," "use any doctor/hospital," and "convenience" as other common reasons. When the reasons motivating choice are compressed into fewer categories, the HMO choosers most often gave service-related (32.4 percent) or access-related (30.3 percent) reasons; while those who picked the traditional system were most likely to give reasons related to choice of provider (51 percent).

Illustration 1

Summary Illustration
Evaluation Criteria (Penetration Rate, Cost, Comprehension Score) Applied to Data, by Method of Demonstration



INTRODUCTION

PHRED History

The Prepaid Health Research, Evaluation, and Demonstration (PHRED) Project was funded in early 1976 by a grant to the California Department of Health from the Department of Health, Education, and Welfare (DHEW), Social and Rehabilitation Service. Funded under the title "Model state quality assessment and cost control system for prepaid health plans," the project was to have a 28-month life. A total of $5,176,483 of federal funding was designated for support.

Sometime after the award date, the Project acquired its permanent (slightly less cumbersome, and definitely more acronymonic) name; a longer life span (due to the numerous delays inherent in two large governmental entities attempting to relate to each other); and a little more money--bringing the total award to $5,448,684.

As indicated by the titles under which the Project labored, its mission was the development of improved management and monitoring methods for the use of states which contract for Medicaid services with qualified HMOs or prepaid health plans. The original proposal for the Project contained a laundry list (the term is carefully chosen) of improvements to be made. They generally fell into three categories:

> Rate-making--The Project first concerned itself with the question central to the survival of the program--the development of a method for the determination of actuarially based capitation rates for the health plans.[1]

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[1]These studies have been reported separately by the Project.

Quality assurance monitoring--Next came the demonstrations designed to let the state agency know what it was getting for its rates--the Quality Assurance studies.[2]

Member-related studies--Always a part of the Project's intentions, although not recognized in the original title, were various studies related to the state agency's need to monitor the interactions of the health plans and their (actual and potential) members: marketing and enrollment, grievance and disenrollment systems, and measures of satisfaction and dissatisfaction. In the fall of 1976, these potential projects were brought together in the third concentration of PHRED resources and activities. Termed Membership Studies, they were proposed to DHEW in 1977 and finally awarded about $1.4 million of the total PHRED funding in July 1978.

Membership Studies staff developed and tested a model system for member grievance resolution and disenrollment processing, as well as an instrument and procedure for measuring dissatisfaction and reasons for disenrollment. Also developed were survey instruments to measure member satisfaction and to gather consumer opinions. These activities constituted about a quarter of the activities of Membership Studies; the bulk of the work was in the marketing-enrollment demonstrations which tested three basic approaches to motivating enrollments in prepaid health plans: various media presenting the Medi-Cal options in the welfare eligibility intake and redetermination processes, mailings of information to eligibles, and (for control) door-to-door solicitation of enrollments and other methods routinely employed by the health plans.

This report presents a description of the marketing enrollment demonstrations and the analysis and evaluation of the data collected.

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[2]These studies have been reported separately by the Project.

Goal

Briefly stated, the PHRED Project marketing-enrollment demonstrations were designed to find a replacement for the troublesome and expensive enrollment method routinely used by most California prepaid health plan contractors--door-to-door solicitation. The California Legislature, in agreement with the Administration, had decided to ban marketing in the streets if a viable alternative method or methods could be found by the Department of Health Services. The overall goal of the Membership Studies demonstrations in marketing was to develop and test such alternatives. The basic measure of success was to be the achievement of a comparable or better enrollment rate at a cost not greater than that of door-to-door solicitation. It was hoped also that the informational and educational spinoff of this change would result in more satisfied, longer-term enrollees.

Background

In a sense, the PHRED marketing and enrollment experiments were almost ten years too late--they were proposed, funded, and implemented long after the time when marketing research should have been done. In retrospect, it would have been most beneficial for the future of the program, in California and elsewhere, to have understood, before a single prepaid health plan contract was signed, exactly what aspects of the delivery system were attractive to Medicaid recipients and how best to make these advantages (and whatever disadvantages existed) known to the segment of the market that was most likely to enroll. But the customer--the consumer-enrollee--was not foremost in the thinking of either the government program managers or the prepaid health plan entrepreneurs when contracts were signed in the early 1970s in California. The concern was dollars--the potential for savings (in the minds of the government managers) and the prospect of profits or expansion of existing services (in the planning of the health plan operators--both profit

and nonprofit). Somehow, it was assumed, the program would attract the poor into the new mainstream of health care--the health maintenance approach.

When the customers did not flock to the doors, the health plans rather frantically went looking for them. The ways in which people were sought out in the barrios and ghettos of California's big cities and the methods used to influence them to enroll have been the subjects of scandal headlines in the newspapers and several Congressional investigations (most notably, those of the U.S. Senate's Permanent Subcommittee on Investigations, Committee on Government Affairs in 1975, 1976, and 1978). The bad impressions left by the overpersuasions and misrepresentations of the door-to-door sales representatives still besmirch the program's image and have crippled and delayed its development in this state and others.

The purpose of this report is not to dwell on past problems or might-have-beens, but rather to describe the research that was finally done and relate its results to today's situation in marketing HMOs to Medicaid beneficiaries. It is not just a case of better late than never; the Medicaid market is ever-changing and the errors and omissions of the past need not necessarily cloud the future. Suffice it to say that marketing research was badly needed in order to maximize the growth of a program that all involved (except the unconsulted consumer) agreed was an idea whose time had come. It did not happen until the concerns of the State and the Congress and the Department of Health, Education, and Welfare coalesced in 1976 with the plan for remedial research and demonstrations of model systems to resolve California's difficulties with managing its prepaid programs and prevent the same problems from happening elsewhere.[3]

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[3]Actually, they did happen elsewhere, in New York, in Michigan, in Illinois, and other states as well. They just happened bigger in California and got all the attention.

The resulting PHRED demonstrations were designed with two objectives: identify the marketplace and maximize motivation to enroll. The approach chosen for research was to regard Medi-Cal[4] beneficiaries as if they were new employees in a company which offered both an HMO alternative and an indemnity insurance plan as health benefit options--to apply the dual-choice concept which had long been the mainstay of HMOs' commercial marketing. Until the demonstrations, such a choice of available options for health care was not offered to MediCal beneficiaries. Solicitors offered enrollment to those whom they contacted; some eligibility workers let some beneficiaries in need of care know about the fee-for-service program and how to use the card, but there was no universal information-giving and choice-offering in the California welfare offices, or elsewhere. The intent of the PHRED demonstrations was to learn about the consumers' perceived needs and preferences in health care delivery systems, while refining a method or methods that would operate to maximize the enrollment of the health plans and assure the program's viability.

Program History

"The California experience," a phrase with negative connotations for those involved with Medicaid and prepaid health, is usually taken to refer to a package of problems which came to public notice in Southern California just before the mid-1970s, after the laissez-faire, caveat emptor philosophy of PHP contracting had brought forth more than 50 health plans in less than three years. Stories in the press concerned quality of care delivered in the health plans, availability of services in emergencies, and missrepresentations by marketing representatives.

[4]Medi-Cal is California's chauvinistic contribution to the "Medi" family of health care programs, for the nation's only individually named Medicaid program.

In the early 1970's, the proliferating California prepaid health plans given Medi-Cal contracts were allowed to use a wide variety of methods to seek enrollments. Little thought was given by the State government officials--or by those requesting contracts--to marketing. Many health plans were surprised, as indeed was the State, to find that Medi-Cal beneficiaries did not flock to the doors of the PHPs. Instead, they had to be found, individually, and made interested, induced, or enticed into enrollment. Because of the confidentiality restrictions of federal and state laws and regulations, the identities of welfare (Medicaid) beneficiaries were protected. The health plans had to find the marketplace and then sell. Individual presentations of information were necessary in most instances, with a few opportunities to approach groups through churches and community organizations. Mailings, designed to motivate the beneficiary to reveal his/her identity and request more information, were tried by a number of health plans, but results were generally disappointing. (Large medical care foundation-backed health plans did generate enrollments through mailings but there was suspicion of possible adverse self-selection. Similar concerns surrounded the enrollment of existing patients of participating physicians into independent practice association HMOs.)

The health plans learned rapidly what did work--solicitation, either by going door-to-door in areas of known heavy concentrations of welfare recipients, or by accosting likely-looking people on streetcorners outside welfare and food stamp offices. Large numbers--more than a quarter of a million--of Medi-Cal beneficiaries were enrolled through solicitation in California, with similar success (but less numbers) in other states. But, although the enrollments were numerous, the marketing costs per member were high and the opportunities for problems were legion.

The initial naivete of the PHP principals in paying for enrollments "by-the-head," using door-to-door salespeople experienced in selling unneeded encyclopedias and housewares to poor people, was shared by

government officials who did not anticipate the possiblity and opportunity for misrepresentation and over-selling of this new and unknown product. The horror stories were many--incentives to enroll ranged from fried chicken dinners to guaranteed cures for the common cold and other less common conditions; enrollment contracts were misrepresented to be petitions calling for the impeachment of a governor unpopular with the poor; continued availability of nonparticipating providers was promised; and more, and worse. The stories were told in the press and on the streets. Advocacy groups organized to help bewildered beneficiaries understand what it meant to join a health plan and to disenroll those who did not want to accept the limitations on providers. A cacophony of complaints reached Sacramento and Washington, and government reacted--some would say over-reacted.

Legislation and Regulation

The government solution--at the state level and in Congress and DHEW--was to pass some new laws and begin heavy regulation of marketing activities. To counter the effects of over-zealous sales presentations, the usual three-day "buyer's remorse" period for contract signers was extended to 30 days for enrollment contract decisions. That is, the enrollment contract signer was given this longer period in which to have a change of mind and be disenrolled automatically. In California, health plans were required to train enrollers who had to pass licensing or certifying examinations, and to verify (by telephone calls to new members) every enrollment that resulted from solicitation. For a period of time, the State also reverified every enrollment by telephoning (and probably puzzling) all enrolling beneficiaries to be sure they really understood what they were getting into. These measures were expanded by a new legal requirement for a viable grievance and complaint system in each plan.

But, despite these protections--which afforded a degree of confidence about the prevention of fraud and misrepresentation in marketing--the

potential still existed in the unmonitored sales presentation in the home. The health plans' difficulties in identifying the market and in paying for the heavy cost of the individual sales presentations also remained as unsolved problems and were barriers to expanded enrolling efforts.

In the last half of the decade, new HMO contracts were few in California and elsewhere. Given the problems and the regulation, the Medicaid marketplace was unattractive and newly qualified HMOs preferred to concentrate on the private marketplace. In California, the program's enrollment was cut in half, as the combined effect of the State's increased regulation and by the Federal government's restriction of contracts to qualified HMOs finally drove "the bad" (or at least the less adaptable) out of the marketplace.

But despite all the problems, Sacramento and Washington remained supportive of the concept of prepaid Medicaid contracts because of the increased accessibility offered to beneficiaries and because of the significant savings afforded by organized health systems over the uncontrolled costs in the fee-for-service sector. Congress considered banning door-to-door solicitation altogether from the prepaid Medicaid program, but was disuaded when it became apparent that there was no other viable method to produce sufficient enrollments to justify a contract with an HMO. Instead, California offered itself as a laboratory for the improvement of the management methods and systems available to state Medicaid agencies. Through the joint concern of key legislators, congressional staff, and officials in DHEW, California's proposal for research and demonstration of these needed management methods was approved and the PHRED Project was funded. Among other charges, the Project was to develop alternative approaches to market contracting HMOs and enroll interested beneficiaries.

In 1977, the State Legislature, having faith in the ultimate success of the demonstrations, passed a law banning door-to-door solicitation by the end of 1978. This proved to be overly optimistic in terms of the Project's progress in developing and testing the proposed alternative approaches, and the deadline was extended. A subsequent law, passed in in the summer of 1980, after the demonstrations in the welfare offices ended and the viability of enrollment through dual-choice presentations became evident, funded implementation of the new method. The termination date for door-to-door solicitation was set for the end of 1981 when full operation in the welfare offices was expected.[5]

Elsewhere, other states have already banned door-to-door solicitation and some are making dual-choice presentations in their welfare eligibility process. A few have actually provided for enrollment in the welfare offices. (See Appendix A for a brief report of a survey of marketing practices in other states.)

[5]Unfortunately, the new program coincided with the cutbacks in the State budget caused by Proposition 13, and full implementation was delayed by limitations on hiring staff to put the new method in place. As of December 1981, the dual choice enrollment method developed by the Project had been put in place in all the California counties in which there are prepaid health contracts for Medi-Cal. To preclude a gap in marketing, the Legislature has allowed door-to-door solicitation to continue on a county-by-county basis until the Department of Health Services determines that the new method of enrolling is fully operational.

Research Questions

The demonstration of alternative enrollment methods was cast in a research mode in order to learn more about the Medicaid beneficiary as a chooser among health care delivery systems. The research questions addressed by the demonstrations are listed below, from most basic to most sophisticated.

1. When presented with a choice between fee-for-service Medi-Cal and prepaid health plans, what percentages of the eligible population choose each?

2. Which method is most cost effective? (In terms of immediate enrollment and in terms of long-range membership stability.)

3. By method used to present the comparison and choice, how many people choose which system of health care delivery? (Is there a viable alternative to door-to-door solicitation?)

4. Does the presentation setting (i.e., group intake, individual presentation) make any difference in the results of the method?

5. What is the difference in comprehensibility and retention of information for each method?

6. Among the five methods demonstrated in the welfare office, are there significant differences in eligibility stability between the choosers of PHPs? Between the welfare office and the plan's current method (door-to-door or other)? Does mail enrollment produce, cost effectively, a representative cross

section of the population in terms of eligibility stability and aid code categories?

7. Is there a significant difference between an "old" eligible and a "new" eligible in the relative effectiveness of the seven different treatments? (new = an applicant for Medi-Cal; old = a beneficiary applying for eligibility redetermination.)

8. Are there significant differences in the choice factors employed by the respondents to the different methods within the welfare office and the plan's current method and the mailing method?

9. Are there significant differences between the eligibility stability of those choosing a PHP and those choosing fee-for-service across the various treatments?

10. Who is the beneficiary most likely to enroll in a PHP (by method)? Who is the beneficiary most likely to choose a fee-for-service card? Who is the beneficiary most likely to avoid the choice situation? How significant is the avoidance of choice? Is it more significant in one method than another?

Areas of interest for choices and profile questions included:

- What difference does the health plan being "under-one-roof" make?
- What difference does a wide choice of providers make?
- What difference does race of chooser make?
- What difference does sex of chooser make?

- What difference does number of children make?

- What difference does having an existing provider make?

- What difference does distance of residence from the source of care make?

- Is there a significant difference between the motivation/responses of a Medicaid group and working populations (as previously reported in the literature)?

Constraints

After the academic formulation of the questions, the realities of performing social service research in a turbulent setting blunted the possibility of answering all of them as clearly as hoped. However, the Project was able to gather the data necessary to provide at least some enlightenment in all areas.

The most significant constraints which were identified during the demonstration process included:

The scarcity of virgins--In the welfare office, people come and go, in and out of the system. Screening for previous exposure to the program required that the research design, by a rather artificial device, separate the "old" program beneficiaries (those who were returning for their annual redetermination or reaffirmation of eligibility) from the "new" beneficiaries, a category which first was defined to be beneficiaries who had not been on Medi-Cal for the previous six months. (The new intake clients to whom Medi-Cal presentations were made were to constitute the experimental sample. The continuing clients encountered during eligibility redetermination were to be put in another group, the demonstration sample.) During the pre-test period and subsequent negotiations with the demontration sites, the Project then recognized that it was somewhat naive, in most of the demonstration sites, to

assume that beneficiaries who had not been on aid in the last six months did not know of or had not been exposed to the Medi-Cal program, whether or not they had ever been eligible. It was all around their neighborhoods, and family members and friends were familiar with the program. (In some areas of hard core poverty, many of the new clients actually turned out to be pregnant teenage girls establishing cases "of their own" after growing up as members of their mothers' cases. Third and even fourth-generation clients were not uncommon.) Faced with these realities, the Project decided to revise the old/new definitions and eliminate the experiment/demonstration distinction in the final analysis of some of the choice factors, although data were collected separately for applicants and redetermination clients and, in some instances, are so reported.

The program's image--The prepaid health plan program in California had been tainted by scandal in some areas of the state. This made word-of-mouth advertising, usually the most effective form, generally negative. Despite major improvements in plan performance and the State's sharp cutbacks of marginal and unsatisfactory health plan contractors, a residue of hostility and suspicion had to be dealt with in each setting before information about the program could be "heard."

Post-Proposition 13 disarray--This was the worst of times to test the addition of anything to the welfare eligibility process in California. Local county welfare department staff members appeared to be demoralized by increased work pressures as county budgets tightened up to meet the tax limits imposed by Proposition 13. Further, the low cost-of-living pay raises offered by county government led to widespread labor troubles (sickouts, slowdowns, strike votes).

And, this was the time period in which major changes to the food stamp program were being implemented by the eligibility workers. Most discouragingly, except for one manager of one demonstration site office, no county welfare worker at any level was encountered who expressed any

enthusiasm or even any academic interest in the research. (The uniformity of hostility toward the demonstrations at least provided assurance that this constraint was real and not just an isolated artifact of a particular office staff.)

Limited cooperation of participating prepaid health plans--Because the marketing demonstrations were directed at finding a viable alternative to door-to-door solicitation, information about PHP enrollers' production rates and costs had to be secured to allow comparison with the costs and rates of the demonstration methods. The higher echelons of the participating health plans, concerned themselves about the high cost of door-to-door solicitation and its associated image problems, were generally very supportive and cooperative. No difficulty was encountered in securing signed agreements that "bound" the PHPs to collect and provide the necessary information. Most health plan executives wanted to find another way to get the members they needed to grow or maintain viability. However, the marketing department staffs, on whom the Project depended for the information, were aware of, and often vocally troubled by, the knowledge that they might be out of jobs if the Project succeeded in developing other methods.

With this clear conflict of economic interest, appeals to intellectual curiosity fell on deaf ears. Further, the individual enroller, who was responsible for collecting data on results of individual encounters, was usually working on commission. The more time he or she spent filling out PHRED forms, the less time to make sales and earn commissions. Although some information was collected and used to prepare the comparative cost data, it was not sufficient and Project staff had to use self-reported plan cost data from a survey of marketing methods, problems, and costs conducted at all plans during the study period by an independent contractor. While this information was not as specific to the study area as was planned, it was felt to be more valid than the spotty reports the Project was able to gather from the enrollers and marketing managers.

Demonstration Site Selection

Seven welfare office sites were selected for the year-long demonstrations. They were: the Pittsburg and Richmond social services offices in Contra Costa County; Alameda County's North Oakland office in the San Francisco Bay Area; the East Sacramento office in Sacramento County in Northern California; and the Westminster office in Orange County and Los Angeles County's East Valley and Florence district offices in Southern California.

These sites were selected because they represented a variety of possible situations: offices in urban, suburban, and rural settings; offices in which there were four possible HMO/PHP choices, and offices with three, two, and one; offices in which there were group meetings for eligibility screening and offices where the encounter was individual; areas in which there had been a negative experience with PHPs in the past and virgin territories newly served by their first health plan; areas in which the HMO was a geographically convenient choice and locations in which the HMOs were not convenient. Despite these differences, each of the sites had the same basic ingredients: administrators, eligibility workers, and clients--all interacting in an environment characteristic of place and time (aftermath of California's Proposition 13 era).[6]

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[6]They also shared at least one other common trait--the attitudes of their eligibility workers toward the PHRED demonstrations. Without exception, none of the eligibility workers at any of the participating sites welcomed the PHRED demonstrations with open arms. Reluctant to add another function to the office, most workers--with the exception of those in Pittsburg, North Oakland, and Sacramento--had also had negative prior experiences with beneficiaries in their caseloads who had previously elected HMO enrollment. In particular, the Florence office had borne the onslaught of the Los Angeles County HMOs--having, at one time, as many as 14 plans all trying to market by pounding on doors. Despite warnings to the plans of illegality, the West Orange welfare office continued to have marketing representatives soliciting enrollment on its property during the demonstrations. The East Valley office had negative reports from clients and lost a plan to bankruptcy during the demonstration.

Two of the participating welfare offices, Richmond and North Oakland, are located in the inner city; three, West Orange, East Valley, and Sacramento, lie in urban areas; and one, Pittsburg, is located in a small town. The seventh, Florence, was described by its director as being "a small neighborhood office in a large city."

The number of applications for AFDC (and thus, Medi-Cal) processed per month by the participating sites ranged from 336 to 1300. This created an average caseload per intake (new applicant) eligibility worker that varied between 20 and 65 per month, depending upon the location of the office. The approved (old applicant) eligibility worker usually maintained a caseload of about 150, averaging 10 to 15 interviews per month in addition to the activities associated with the ongoing maintenance of cases.

During the course of the PHRED demonstrations, four of the seven demonstration site offices reported a change in the types of people applying for aid, namely, more single women and couples with unemployed husbands entering the system. Some offices noted an influx of people from other states and countries. Three of the sites had caseloads consisting primarily of second- and third-generation AFDC recipients.

Each of the participating sites is described in more detail below. In addition, the narrative descriptions are followed by Exhibit I which compares caseload, staffing, and client data for the seven sites.

Site Descriptions

The West Orange welfare office is one of three offices located in Orange County in Southern California. The clients, primarily white women and men, are viewed by the office staff as "definitely not lower class but people who are temporarily down on their luck." This may well be an accurate observation--of the 500 applications processed monthly, most beneficiaries did not remain on aid long enough to require an annual redetermination interview. This demonstration site was served by three health plans, one of which ceased contracting with the State during the course of the demonstrations.

The Florence District office is one of 37 welfare offices in Los Angeles County. Florence is an inner-city area of the Los Angeles ghetto-barrio. The majority of clients are black and brown with an increasing number of illegal alien mothers applying for aid for their American-born children. The people who live in this area are not temporarily down on their luck; they require long term assistance. The majority of the Florence clients are second- and third-generation AFDC recipients--the average intake applicant proved to be an "old" client who had neglected to meet the county's monthly reporting requirements. Four competing health plans served this area during the PHRED demonstrations.

The East Valley District office is located in the San Fernando Valley in Los Angeles County. Its clients, once primarily white, are now racially and economically mixed. The waiting room was often filled with families--some of whom had driven across the country and were living in their cars--plus a number of Jordanians, Thai, and Vietnamese immigrants. There were also black and brown AFDC recipients trying to get away from the Los Angeles inner city. This influx of AFDC-eligible people to the Valley increased the caseload of the 18 intake workers who were processing about 800 applications per month each. Three health plans served this area at the beginning of the demonstrations; one ceased contracting with the State before the demonstrations concluded.

Pittsburg and Richmond are the two demonstration site offices serving Contra Costa County. Although located within 40 miles of each other, they serve entirely different populations of eligibles. Both are located within the service area of the nation's only county-operated qualified HMO, the Contra Costa Health Plan, which has contracted with the State for a number of years.

The Pittsburg office, which at one time served a rather stable group of the town's poor, was experiencing a surge of new applicants. The office director attributed this phenomenon to the economic recession which resulted in heavy industrial layoffs, and to the increasingly high cost of housing in surrounding areas around the San Francisco Bay which forced the poor to move to more-affordable Pittsburg.

The second Contra Costa site, Richmond, serves a more constant, economically depressed population. The majority of its clients are black, with a large member of hispanics as well; most are second- and third-generation AFDC recipients. The office has attracted a politically active staff which prides itself on "looking out for the community"--a term often used by the eligibility workers.

The North Oakland office is one of three in Oakland (Alameda County). Located in a racially-mixed inner city, most of its 390 monthly applications are from people who have recent prior AFDC experience. The North Oakland office maintains a staff of 54 approved caseworkers serving an average of 8200 on-going AFDC cases. The low caseload of the intake workers (20 per month) is due primarily to the office's use of a group intake procedure which serves as a preliminary screening process. There was one community-based health plan serving the population of this demonstration site.

The Sacramento office, originally intended as a "small neighborhood" office, has lost those characteristics as the caseload has increased.

Exhibit I

Comparison of Demonstration Site Welfare Offices

	West Orange	Pitts-burg	Rich-mond	North Oakland	Sacramento	Florence	East Valley
1. Intakes per month	500	1300	222	390	400	336	810
Number of Intake Workers	16	20	16	19	8	12	18
Group Interviews	NO	NO	NO	YES	NO	NO	NO
2. Number of Approved Workers	29	24	23	54	19	48	44
Caseload Size	135-150	150	168	152	148	173	126-150
3. Geographical Location	Urban	Rural	Inner-City	Inner-City	Urban	Inner-City	Urban
4. Majority of Applicants							
New to AFDC System	X	X			X		
Prior Recent Experience			X	X		X	X
5. Ethnicity of Clients							
White	Major-ity	Major-ity	X	X	Majority		X
Black		X	X	X	X	Majority	X
Mexican-American		X	X	X	X	X	X
Other		X	X	X			X
6. Prior PHP Experience	Nega-tive	Posi-tive	Neu-tral	Neutral	Neutral	Negative	Nega-tive

	West Orange	Pitts-burg	Rich-mond	North Oakland	Sacramento	Florence	East Valley
7. Number of Health Plans	2	1	1	1	1	4	2
8. Marketing Method* Used by plans in area	DS OS WOM	WO IH	WO IH	DS OS	IH M	DS OS WOM	DS OS WOM

*DS = door-to-door solicitation
OS = other direct solicitation
L = Leads, referrals
IH = in house marketing to patients with the plan facility
WO = referral to plan worker in county welfare office
M = Mailing
WOM = Word of Mouth (no direct marketing)

The eight intake workers now process 400 applications per month. The large average caseload has led to turnover in staff as workers become increasingly dissatisfied with the job. Here, the majority of the applicants are new to the AFDC system. They do not necessarily live in the immediate area; the office also processes applications for several other offices. One health plan serves the population of this site.

Selection of Demonstration Methods

From the early 1970s to the present, HMOs contracting with the State have used a plethora of marketing methods to educate potential members about the benefits of enrolling in their health plans. These methods have ranged from wholly passive--"I'll wait until the client comes to me"--to totally aggressive--highly focused "search and enroll" missions. Between these two extremes lies a broad spectrum of methods to inform potential members about the benefits of enrolling in a health plan and to motivate them to select the source of their health care.

For reasons discussed earlier in this report, the State began to search for alternatives, through the PHRED Project research, to the troublesome door-to-door marketing approach. This section of the report discusses the alternatives which the PHRED Project chose to demonstrate and explains why these particular methods were chosen. Also described are some methods which were purposely excluded from the demonstrations, with related rationales.

Of the many methods considered, seven (five of which were tested in the welfare offices) were eventually selected for demonstration. They were:

Welfare Office Methods

The five methods demonstrated in the welfare offices use of a printed brochure, a film, and separate (but identical) presentations by State,

county, and HMO representatives. A script, reinforced by "flip" charts for visual aid, was followed for personal presentations by the county eligibility worker, the State (PHRED) worker, and the HMO representative. (The latter was monitored by tape recording by the PHRED field representatives.) In each case, the information presented was the same. (Copies of the basic information pieces and of the HMO descriptive folders can be found in Appendix B). The oral presentations, as well as the specially produced film, were supplemented by the printed brochure.

Although the Federal and State regulations and the forms used were the same in each welfare office, procedures for establishment of eligibility for public assistance applicants differed markedly, even within the same county welfare system. Some counties employed a detailed screening process before the applicant saw an intake worker; others referred the applicant to the worker after only the briefest of checks. Some counties made home calls; some gave group intake sessions; others interviewed applicants individually in the welfare office.

Thus, the precise demonstration scenario for giving information and requesting a choice in the eligibility process was unique to each office. In all cases, the strategy was the same: give the information and request a choice. Only the timing and the physical setting varied. (These schedules and settings constituted some of the independent variables of the analysis.) Detailed descriptions of the procedures followed in one office are presented as an example in one set of scenarios (Appendix C). Data collection forms used in all sites are also provided (Appendix D).

The PHRED demonstrations were located in the welfare offices for several reasons: the setting was objective; the presentations were monitorable; and, most importantly, they were the only places in which the universe of potential enrollees could be exposed to the choice information. The welfare office is the place where eligibility for public assistance programs is initially determined and the client is required to partici-

pate in a face-to-face interview. Subsequent redeterminations of eligibility on an annual basis are conducted in a similar fashion. Thus, all recipients of public assistance are required to appear at the welfare office at least annually.[7] Within this milieu, AFDC cash-grant public assistance Medicaid eligibles constitute the population eligible to enroll in a local HMO contracting with the State.

In addition, the welfare office is an important environment for its clients. Despite hostilities to the system and frustrations with its processes, the beneficiary of public assistance usually looks to the welfare office for information vital to survival. In locating the choice situation within the office, the Project hypothesized that benefits would be realized from the credibility attached to the office as well as its effectiveness as a single information network. The selection of health care benefits was a natural extension of the eligibility determination/social services functions in the offices. Choice of health benefits in this setting parallels the dual-choice selection made by new employees. With the choice situation within the welfare office, the major raison d'etre for door-to-door solicitation--locating the marketplace--was eliminated.

Despite the advantage of universal access to beneficiaries, it was recognized that these offices--to which people come with desperate, immediate needs for money and other relief from pressing problems--were not optimal settings to educate Medicaid beneficiaries about anything as future-oriented as the choice of a health care delivery system. The Project (erroneously) anticipated that many people would be unable to make a decision on the spot and a special data analysis category was created for non-choosers.

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[7] In some county offices, home calls are made by the welfare workers, but the principle of having annual contact with the office remains the same.

Also carefully considered were the advantages and disadvantages of the five media selected for the welfare office presentations, the Project's "best bets" for finding a method or methods to produce a viable market presentation and replace door-to-door solicitation. Each was selected after consideration of a number of factors, as described below.

Brochure. Giving the client written materials without the benefit of verbal explanation tested two hypotheses. First, that the client would, in fact, read the materials. Second, since this method appeared to be the least expensive of all alternatives, the post-Proposition 13 mentality of public financing might not allow implementation of a more ambitious or sophisticated method of providing information in the welfare office and it was important to evaluate its viability.

Film. An audio-visual approach appeared to have great potential for a variety of reasons related to welfare office environment: a single film, shown on a automatically projecting film cassette, would standardize the presentation and information conveyed; additional staff would not be needed to operate the equipment or to give the presentation; the dull, monotonous climate of the welfare office, where people's voices become all there is to hear, could be interrupted in a positive fashion to get the attention of the client; clients, who seem to view many hours of television programming, would feel more comfortable with this medium than with reading written materials, and, because of this, might be more attentive to the message.

Eligibility Worker. A personal presentation by a county eligibility worker was a necessary component of the demonstrations because of the very setting of the choice situation within the welfare office. The logical extension of placing the choice within the office is to have the client's worker provide appropriate information and elicit the choice. To the client, the eligibility worker represents a collage of figures: the authority, the social worker, the information-giver, and the problem-solver. It was assumed that this person, the primary link to a monthly cash grant allotment, would be credible in the eyes of the client.

Past PHP scandals in California, however, put enough of a cloud over this method to make the test intriguing. Some eligibility workers still remember the problemmatic early years of the prepaid health plan program. There was concern that the worker would not be knowledgeable enough about the HMO industry to provide good information and, moreover, might be biased against it. Some HMO representatives feared eligibility workers would "shield" their clients from the HMO information ("in the clients' best interests"), make the choice for the client, or sway the client's opinion with the influence of their authority to approve applications for welfare grants.

HMO Representative. The HMO industry claimed that only well-trained solicitors, familiar with the peculiarities of the health plans, could put the information in an appropriate perspective for the client. The characteristic search of door-to-door solicitation could be eliminated by allowing an HMO solicitor to make presentations to clients in the welfare office setting.

Critics were primarily concerned about the confidentiality requirements which protect welfare beneficiaries and about the recurrence of past problems. It was feared that solicitors would not be professional (in terms of "what's best for the client"). They thought the welfare office would be admitting the wolf through the door and, in effect, would be sanctioning the concept of prepaid health as preferential to fee-for-service providers in the community. Proponents, however, hoped that the image of the health plans would be improved by their representatives' presence in the welfare office and that their developing professionalism would be strengthened.

State Worker. It was believed that a state representative, familiar with the HMO industry but detached from its marketing expectations, could provide an objective presentation in the welfare office without the stigma of the "fast sell" representative. Confidentiality requirements would not be infringed. Because this method was a compromise

approach, the HMO industry feared the state representative would be too far removed from the health plan's operations to be really knowledgeable, while the welfare departments worried that the State, as the purchaser of services, would have a too active interest in moving clients into the cost-effective prepaid health system.

Mailing Method

As mentioned earlier, marketing by mail was a method of interest because of its relatively low cost and its controlled objective message. In the demonstrations, the Department of Health Services mailed the PHRED information package to each eligible beneficiary[8] living within the ZIP codes served by the demonstration site welfare offices. The package (in Appendix B) contained a cover letter explaining that the beneficiary had a choice to make about Medi-Cal, a copy of the same general folder used in the welfare office demonstrations, separate folders for each health plan serving the area, and a choice card to be used for enrollment or to request a visit from a health plan representative for further information. Beneficiaries who elected enrollment received a telephone orientation and verification call from the health plan to be sure that their understandings of the health plan were correct (script in Appendix E).

Those who asked for more information were visited by health plan marketing representatives. The Project followed up on all enrollments, asking the same questions used to gather data about retention and comprehension of the information presented in the various welfare office demonstrations (telephone follow-up questionnaire in Appendix D).

[8]Mailing was the only method which presented information to Medicaid beneficiaries in aid categories other than the cash grant AFDC group. That is, when information was sent to all the eligibles in the area, approximately 35 to 40 percent were in the adult aid (State Supplemental Income--SSI) categories--the aged, the disabled, and the blind--those whose eligibility was determined at Social Security offices rather than at the welfare office. Medically Needy beneficiaries with no share of cost received the mailings; those who had a share to pay did not because they were not then (and are still not) enrollable in California PHPs/HMOs.

This alternative method also was demonstrated for several reasons: Mass mailings from the Department of Health Services (DHS) on behalf of the health plans have been commonplace over the years. This method of marketing, a fairly inexpensive way to reach the elderly, blind, and disabled aid categories, was encouraged by DHS in order to ensure that contractors met their obligations to enroll within all eligible public assistance aid categories. Additionally, the use of direct mailings in other areas of commercial marketing was already well established.

The mail method had the advantage of reaching the total market of potential enrollees who lived within the area of the mailing. Seekers of health care who were new to the public assistance sector, however, first received a standard fee-for-service Medi-Cal card before they were placed on the mailing list which identified this market. From the HMO perspective, there was an inherent disadvantage to this method because all potential enrollees (especially new eligibles) had already been exposed to the fee-for-service system before the mailing reached them.

Critics of the direct mailing method also claimed that much mailed material would never be read or understood. In the Medicaid marketplace, it was thought (although not substantiated for the population studied), the illiteracy rate would be higher than in the general population, thereby making a direct mailing approach to Medi-Cal eligibles even less viable. Finally, there was a concern that only those who perceived a need for health care would respond to a self-enrollment method, such as the direct mailing approach. As a result, the plan's projected patient population would be skewed, with a high concentration of service utilizers ("adverse self-selection").

The Project wanted to try marketing by direct mail to determine whether self-enrollment after receipt of mailed information would be a viable and productive strategy, particularly with the harder to reach adult aid (SSI/SSP) categories. Additionally, PHRED hoped to determine whether

This alternative method also was demonstrated for several reasons: Mass mailings from the Department of Health Services (DHS) on behalf of the health plans have been commonplace over the years. This method of marketing, a fairly inexpensive way to reach the elderly, blind, and disabled aid categories, was encouraged by DHS in order to ensure that contractors met their obligations to enroll within all eligible public assistance aid categories. Additionally, the use of direct mailings in other areas of commercial marketing was already well established.

The mail method had the advantage of reaching the total market of potential enrollees who lived within the area of the mailing. Seekers of health care who were new to the public assistance sector, however, first received a standard fee-for-service Medi-Cal card before they were placed on the mailing list which identified this market. From the HMO perspective, there was an inherent disadvantage to this method because all potential enrollees (especially new eligibles) had already been exposed to the fee-for-service system before the mailing reached them.

Critics of the direct mailing method also claimed that much mailed material would never be read or understood. In the Medicaid marketplace, it was thought (although not substantiated for the population studied), the illiteracy rate would be higher than in the general population, thereby making a direct mailing approach to Medi-Cal eligibles even less viable. Finally, there was a concern that only those who perceived a need for health care would respond to a self-enrollment method, such as the direct mailing approach. As a result, the plan's projected patient population would be skewed, with a high concentration of service utilizers ("adverse self-selection").

The Project wanted to try marketing by direct mail to determine whether self-enrollment after receipt of mailed information would be a viable and productive strategy, particularly with the harder to reach adult aid (SSI) categories. Additionally, PHRED hoped to determine whether

those who enrolled themselves after receipt of mailed information used the health plan services more than those who chose to enroll by some other method, thereby fulfilling the prophesy of adverse self-selection.

Current HMO Marketing Methods

The third basic marketing method tested by the demonstrations--door-to-door and other methods of solicitation--was, of course, the health plans' responsibility. They continued to use their own materials, presentation methods, and selling techniques in the demonstration areas during the periods assigned to them. The only difference from their usual operations was the submission of response and cost data to enable comparison with PHRED demonstration methods in the welfare offices and with the mailing.

Each health plan had a "canned" presentation which enrollers were supposed to use in door-to-door solicitation or other marketing situations. Although it was not possible to know whether the script was followed exactly, HMOs verified enrollments for enrollee understanding of the meaning of enrollment. It is assumed that the same information was given in order to prepare the new enrollee for the verification interview.

Untested Alternatives

A wide variety of other possible approaches to marketing were considered in planning the dual-choice demonstrations. The more significant of these alternative methods, and the reasons for their exclusion from the demonstrations, are listed below:

1. Assignment--Although this is a possibility under a federal waiver and under authority of California's pilot project legislation (which

allows assignment if the beneficiary is given the right to opt out within 30 days), the Project did not test it since the Department preferred first to see the results of a positive choice-making process offered universally to all beneficiaries in the eligibility process. Concerns for the effect on program growth of "forcing" beneficiaries into health care options were expressed and strong opposition from welfare rights and health rights organizations was anticipated.

2. Enrollment through community groups--This approach was one of the planned methods for demonstration; however, the Project was unable to find a group willing to take on the data collection and reporting responsibility. Several groups expressed initial interest, but funding possibilities were limited and no proposals were received.

3. "Improvement" of current door-to-door solicitation methods--Because the policy decision had already been made in California (and was perceived as probably forthcoming from Congress as well) to abolish door-to-door marketing as soon as alternatives were available, the Project did not consider what might be done to make door-to-door marketing more palatable to consumers and policy-makers. The high cost and difficulty of monitoring inherent in the one-to-one marketing process in the home cannot be modified;[9] further, the Department recognized that health plans, generally, had already improved the method about as much as possible. Instead, PHRED used the health plans' current marketing methods (including door-to-door solicitation) as the source for control data against which to compare the results of the demonstration methods.

[9]Door-to-door solicitation has other drawbacks as well. Beneficiaries enrolled in their homes often perceive a pressure from the presence of the enroller alone. Pressure to enroll was identified in the 1979 survey of satisfaction of Medi-Cal enrollees of all California prepaid health plans as the single greatest factor likely to cause dissatisfaction and prompt disenrollment. Plans whose enrollees reported more often that pressure to enroll was a factor in their decision to enroll were also ranked lowest in overall satisfaction with plan membership.

4. Dual choice in the SSA offices--Offering the choice, in the same fashion as AFDC, to SSI recipients during their eligibility process was the initial intention of the Project. However, it would have been necessary to make major revisions in the State's contract for eligibility determination with the Social Security Administration (which precludes any social services) in order to to carry on demonstrations within the eligibility process for adult aid category recipients. The amount of time required for such revisions made it impossible to have concurrent demonstrations. The Project did include beneficiaries in these aid codes in the mailing demonstrations.

5. Mailing on a flow basis to new eligibles--Another alternative which the Project regretfully had to abandon for demonstration purposes was the idea of sending information to each new eligible from the welfare offices on a flow basis, rather than the mass mailing approach demonstrated. It was felt that more efficient and timely responses could be made by the health plans if the mailing were spread out; however, it was not possible to set up such a system in the social services offices on a demonstration basis when only a portion of the applicants were part of the demonstration sample.

6. Demonstration of the HMOs' sales approaches within the welfare offices--The best test of the HMO representative method would have been to allow the representative to make the plan's usual sales presentation to the beneficiaries in the welfare offices. The test then would have been directly of the kind of information presented by the (presumably) objective government worker--state or county--with the (presumably) more subjective presentation of the HMO employee. Although this would have been possible theoretically in an office in which there was only one health plan as an alternative, it was not practical in offices in which there was more than one HMO option. Clients would not have been able or willing to sit through numerous (up to four) iterations of competing plans' virtues and advantages. Further, the existing antagonism and suspicion toward HMO marketers expressed by most of the county welfare office staffs would not have allowed a "sales" presentation. Counties

uniformly were only willing to participate as demonstration sites with assurance that there would be no attempt to "sell" HMOs, only to offer the choice. Thus, the HMO representatives were limited to presenting the same information as the other media employed. In areas of competition, they were not allowed to reveal their own plan's identity and were required to present information about all of the options in the area.

Research Design

The original plan for the demonstrations did not address experimental design since the Project's initial charge was to test and implement changes in current systems, rather than to carry out an actual experiment. With the establishment of HCFA, the federal conception of the Project's purposes took on a research orientation. Thus, the second draft of the plan to evaluate the demonstrations in the welfare offices contained a more rigorous design for experimental research. The design selected was a Latin Squares configuration. Each treatment was to be applied in each setting; however, modifications in the classic design were necessary and methods were finally tested according to the schedule shown in Exhibit 2. (The modifications were caused by labor relations problems which surfaced during negotiations with the demonstration sites, delays in making the film because of the State's lengthy contracting process, etc.) As suggested by the research questions relating to profiling choosers, analysis of variance was planned.

Data Collection

All of the marketing methods demonstrated in the Membership Studies experiments in the seven welfare office districts had the same objective: to produce sufficient enrollment at a reasonable cost. "Sufficient" and "reasonable" were standards quantified through a practical definition for this setting:

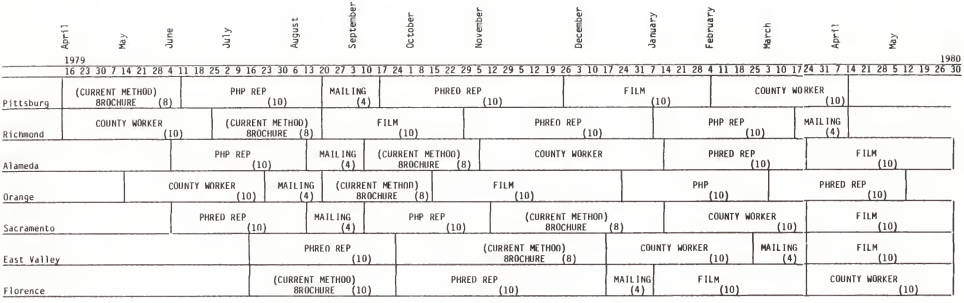


EXHIBIT 2
DEMONSTRATION SCHEDULE

An enrollment method must produce the minimum acceptable number of enrollments to enable the PHP to maintain its level of membership or cause it to increase (whichever policy would be adopted by the plan and the State), and it must do so at a cost per enrollment which is tolerable to the plan. (The tolerance level could be roughly approximated by the plan's current expense for marketing; that is, to be successful, a method must cost no more than the current method, and preferably less.)

Data were collected to measure both effect of the informational presentations and the costs associated with each method, although it was recognized that effect and cost would become somewhat blurred if a particular presentation method produced enrollments of longer duration than another more immediately productive method which did not result in increased enrollment stability. Instruments were pretested. (See Appendix F for reports on pretests.)

The sample--The populations sampled comprised the Medicaid beneficiaries eligible to join a prepaid health plan who lived in the service areas of the seven welfare office demonstration sites. The selection method for the welfare office samples consisted of applying the various treatments to the clients of designated eligibility workers. Statistical randomness was assumed because the applicants for welfare--and Medicaid--were assigned on a rotating basis to workers and there was no other factor involved in their assignment. Within each sample, beneficiaries were exposed to one of the five information presentation treatments in the welfare office; the entire eligible population of the area was exposed to the mailing, while an eclectic sample received information from the health plan's usual marketing method. Each treatment was applied in each setting; methods were scheduled according as illustrated in Exhibit 2.

Ideally, it would have been possible to present information to all the clients of the demonstration site offices. However, the already overburdened welfare offices were not able to take on such a massive procedural change in the post-Proposition 13 era. As noted above, the sample (in most instances) comprised the clients of identified individual eligibility workers. For each method, at each site, a minimum of 100 presentations to eligible new beneficiaries and 100 to eligible redetermination clients was planned (and in most instances accomplished). To collect data on 200 eligibles, additional encounters were recorded to offset the drop-out of applicants determined to be ineligible later in the process.

The setting--The setting for collection in the welfare office was the eligibility process itself. A "new" person seeking aid (financial, medical, or social services) came to the office and made an application for assistance under the Aid to Families with Dependent Children (AFDC) program. In most counties, a screener went through a short form, interviewed the applicant, and, if he or she appeared eligible, scheduled an appointment with an eligibility determination worker--sometimes for the same day, more often for several days or a week or more later. The applicant was usually given a large packet of information and forms to read and fill out before the appointment. Much documentation was also required.

The marketing demonstrations intruded into the process at this point. The client was given the Medi-Cal choice information through one of the methods and was asked to make the choice, sometimes on the spot, but usually later, turning in the choice form when he or she saw the eligibility worker.

The process was similar for the annual redetermination (the "old") eligibles, except that the packet of forms and information was usually included with the appointment letters routinely sent to continuing

clients. These clients made their choices at the time of the redetermination interview, after some reinforcement information was presented (except when the brochure was the sole method of demonstration).

The setting for the mailing method was of course the beneficiaries' residences while the HMO's current methods had varied locales. In most instances, "cold" door-to-door solicitation was used to identify and contact the market, often in combination with leads from the ranks of existing patients or efforts to enroll patients within the health facility. Other soliciting efforts included standing outside the welfare office or food stamp store and approaching likely looking people. One plan (Contra Costa County) already had staff in the welfare offices who made presentations and enrolled (interested) beneficiaries referred by eligibility workers. Kaiser, in Southern California, did not market directly but did accept enrollment from previous (non-Medi-Cal) members or those responding to word-of-mouth advertising. Observations of the plans' solicitation practices are reported in Appendix G.

The data--A wide variety of data were collected for each of the seven demonstrated methods. Specific variables are best identified by a review of the forms used throughout the demonstration process (included in Appendix D). In general, however, the variables can be divided into the following categories:

- Demographic information, e.g., age, sex, race, etc., on the beneficiary.

- Beneficiary choice and presentation information, e.g., health care choice, presentation setting.

- Comprehension and retention information, and data on attitudes about Medi-Cal and health care.

The next sections of this report explain in more detail the data collected.

Evaluation Factors and Analyses

The evaluation plan for the marketing demonstrations provided for comparison of results in two dimensions--intermethod and intramethod. These terms are defined in this section and the data for each are described, as is the Project's success/failure in carrying out its original plan.

Intermethod Analysis

Intermethod was defined as a comparison of results of one medium of presenting the choice information with each of the others. That is, each of the five media used in the welfare offices and the mailing and door-to-door solicitation methods were to be compared with each other. The planned and completed measures were:

Planned	Actual
Response Rates (of all eligibles in area)	Responses to Presentations (Enrollment Rate)
Enrollment Costs	Enrollment Costs
Survival Rates (ratios of enrollments to disenrollments)	Length of Eligibility (for non-representative sample only)
Comprehension of Information	Comprehensive Scores
Acceptability (State, county, HMO and beneficiary groups)	Acceptability (without beneficiary groups)

Data for the first four measures were aggregated statewide and site by site. (The original intention to compare methods by other aggregations of locations, and HMO by HMO, did not prove productive.)

Response rates--Success was to have been evaluated by the ability of a method to generate the response rate necessary either to maintain current enrollment or to produce the desired growth rate. In the original

design, a criterion was to be established for each HMO, based on its growth projection for enrollment in the area. This estimate was to serve as the unit of analysis for the demonstration. However, some of the demonstration areas turned out to be locations in which the health plans did not usually market and thus no definite projections were available. Without this measure, it was possible only to compare the overall demonstration results with the HMOs' current marketing results.

The enrollment response rate was determined as a simple ratio between the number of choices for prepaid health plans and the number of presentations. For each method, including the five welfare office media, a minimum of 1,220 presentations of information and resulting choices occurred, although the goal of 100 choices per method per site was not achieved. The total choices for prepayment were divided by the number of presentations to obtain the ratio. Additional statistics of interest included the number of family members enrolled by each decision-maker.

Enrollment costs--The criterion for this measure was the achievement of a cost per enrollment which was equal to or less than that of the health plan's cost for the usual marketing method (in most cases, door-to-door solicitation). The measurement was to be made against cost data reported by the plans for their marketing activities in the demonstration area. As described earlier, these data proved difficult to gather and their validity was so doubtful as to preclude their use in the analysis. Instead, the Project used cost-per-enrollment figures supplied by the plans during the study period to an independent contractor carrying out a survey on marketing methods and costs as part of a technical assistance effort for the Department of Health Services. Costs for the demonstrated alternative methods were established from Project costs and from the records of county staff time spent on the demonstrations. (An attempt was made to exclude costs related to the demonstration data collection; however, the amount may still be higher than would be the case under actual conditions.)

Costs for mailing method enrollments were put together from the Project's costs for printing and mailing and the health plans' reported costs for necessary follow-up activities. (Further information about the data and their validity in the cost analysis is given later in this report.)

Survival rate: Ratio of disenrollments/enrollments--According to the original evaluation plan, to be successful, an alternative method had to produce enrollments with the same or greater stability as those generated by door-to-door solicitation. Stability was to be assessed by compiling data from the Department's eligibility history file to produce statistics for survival rate by method.

The benefit to the enrollee was assumed to be accessibility and continuity of care; for the health plan, it would mean greater predictability of membership, and, in the long run, perhaps, lowered costs of care (if preventive health care has such results). For the State, the benefit could be more easily quantified--the savings factor over fee-for-service utilization costs (approximately 15 percent) may be applied to every PHP enrollment month and a cost benefit estimated for each method.

Because of the short time of the study and the poor data quality from both the State and the HMO sources, disenrollment rates were difficult to determine with exactness. (For the first reason, disenrollment rate determination was not included in the products described in the final proposal for Membership Studies.) However, some attempt was made to describe the enrollment/eligibility history of the enrollees. After the end of the demonstration period, the PHRED file of demonstration enrollees was matched against the eligibility history file. It was not possible to "find" a large number of the subjects within the file, either because they never became eligible, or their identification numbers were not correct in the Project's records, or because the condition of the State's eligibility history file did not allow

uniform abstraction of these data within the Project's time and funding constraints. With these limitations, the Project decided not to carry out the rather ambitious life table and survival rate analysis that had been planned.[10]

Comprehension of information--An indirect measure of effectiveness, testing of comprehension of information presented assumed that an informed choice would result in a "better" enrollment in that there would be decreased reason to disenroll and appropriate use of services would be more likely. Ten true-false statements were used to measure beneficiary comprehension (Appendix D). All beneficiaries electing enrollment who could be reached by telephone or mail were surveyed for their understanding of the system, as were a sample of those who chose the fee-for-service system.

Acceptability--To assess the extent to which a marketing method was acceptable to those affected by it, the Project created an "acceptability score" to be gathered from three groups--the health plans, county welfare department staff, and State administrators. (Beneficiaries were not surveyed directly although advocacy groups offered advice on the content of the presentations and generally welcomed the dual-choice strategy.) A case-by-case approach was employed to create an acceptability score based on criteria relevant to each interest group. Criteria for each group included the following:

- HMO contractors: Cost per enrollment, administrative ease or difficulty, retention of resulting enrollments, comprehension

[10]It might be feasible in a future study for the Department of Health Services to follow the subjects of the marketing-enrollment demonstrations for as long as they are of interest, since they are filed in the computer by method of enrollment. The file could be run against the Department's eligibility history file to check PHP enrollment status after concentrated data clean-up efforts to identify more subjects. Those reported as disenrolled then could be checked through the Department's disenrollment records for each plan to ascertain the reasons for disenrollment.

and satisfaction of resulting enrollees, and number of enrollees.

- County welfare departments: Acceptability to line staff, supervisors, and management; time and supervision difficulties; compatibility with existing system for eligibility determination; cost (passed on to the State); suitability to mission of office staff, problems created, and problems solved.

- State: Cost, compatibility with existing system, administrative ease or difficulty, numbers of enrollments, attractiveness of method to potential new contractors.[11]

Intramethod Analysis

Comparative measures--While intermethod analysis focused separating the methods, comparing the results of one medium with each of the others through several measures to enable evaluation, intramethod analysis was planned to assess the effects of the independent variables within each method. This analytic approach was disappointing because of data problems and the limitations of the sample. Where sufficient numbers of beneficiaries enrolled, a profile of the person most likely to enroll or not enroll--by method--was to be produced. However, when the data were in hand, the variables, considered on a method-by-method basis, seemed intertwined in effect. Again, time and staffing limitations did not allow the full regression analyses that would have revealed which variables were irrelevant and which were powerful and predictive. The

[11]The State acceptability criterion was self-applied by the Department of Health Services in advance of the final evaluation phase of the demonstration. That is, the Department staff and management carried out the evaluation of the dual-choice welfare office approach through the usual budget review process. The proposal for implementation appears in Appendix H.

definitive profile of interest was not produced; preliminary indications are presented in the analysis and results section.[12]

The variables planned for analysis are listed below in the first column, with the more specific category actually used in the analysis designated as "actual":

Planned	Actual
Location (urban, rural, etc.)	Site per se
Presentation setting characteristics (group, individual, couple making choice)	As planned
Age	Age
Race	Race
Sex	Sex
Previous Medi-Cal eligibility (fee-for-service or prepaid)	History
Plan characteristics	Not attempted

Two main data sources were used to gather the data for these comparisons: the telephone survey, which attempted to ascertain reasons for choices and assess comprehension of information presented, indicating the factors the subject found important enough to remember; and the survey which collected demographic and choice data at the time of selection. Included were data related to existence of a previous provider relationship and satisfaction with it, distance from the location of care, perceived advantages of the chosen system, and previous knowledge of the system(s). (It should be noted that some subjects were not reachable by telephone and did not respond to the mailed survey, thus data were not available for all in the sample. The sample itself may not be representative of the entire Medi-Cal population since those who were clients at the demonstration sites were not necessarily a micro-universe of the statewide population.)

[12]After the end of the Project, the Department cleaned and edited the data file and it is available for more detailed analysis by other researchers.

Availability of Data for Analysis

All data for the intermethod and intramethod analyses were accumulated on a chooser-by-chooser basis in computer-processable files. The record for each individual contained the information on the basic data form (see Appendix D, item 1), the choice form completed by each subject (item 2), and the results of the comprehension-retention test administered to each enrollee who could be contacted and to a sample of those choosing the fee-for-service system (item 3). For those enrolling, results of the verification of understanding survey (which was administered by the chosen health plans) also were to be available (Appendix E), however, plans almost uniformly did not carry out the survey.

The file of "choosers" was maintained by the Project as the basic resource for all analysis. Also available in some instances were data on individual histories from the eligibility file.

Plan for Analysis

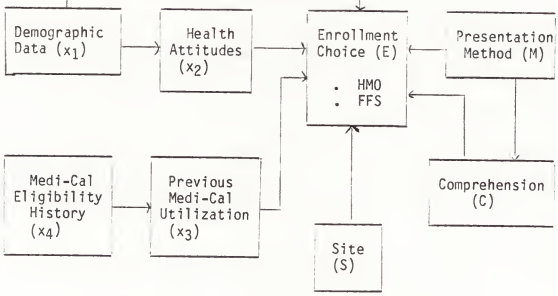
Conceptual framework--The conceptual framework into which the marketing enrollment data were placed is expressed by

$$E=f(x_1 \ldots x_i, M, C, S)$$

where E equals enrollment choice which was hypothesized to be a function of x_1 to x_i independent variables, C is the beneficiary's comprehension; M, the method of presentation; and S, the influence of a number of aspects of the site variable.

The possible relationship and dimensions are expressed graphically:

DIAGRAM 1



where demographic data are directly related to enrollment as is previous utilization.

Demographic variables (x_1) are posited as differentiating choosers' attitudes (x_2) about the relative importance of health, and thus enrollment. Medical history (previous utilization, x_3) is also assumed to be related to enrollment as is Medi-Cal eligibility history (x_4). The method of presentation is related to choice, to comprehension, and to the length of enrollment. Site, as a comprehensive variable which subsumes many aspects of a locale and its population's characteristics, is directly related to choice.

The relationship between method and length of enrollment is illustrated in a corollary hypothesis concerned with the existence of a relationship between length of enrollment (L), beneficiary comprehension (C), and method of presentation (M).

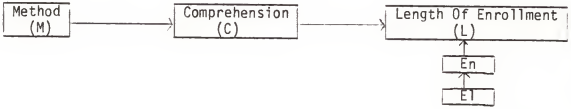
This is expressed:

$$L=f[M,C,En(El)]$$

where L is length of enrollment; M, method of presentation; C, beneficiary's comprehension of the program; El, chooser's eligibility to receive benefits; and En, enrollment.

The proposed relationships are expressed graphically below.

DIAGRAM 2



Where length of enrollment (L) is related to method (M) through the beneficiary's comprehension (C), and is also affected by the beneficiary's eligibility and enrollment.

Dimensions of Analysis

The marketing enrollment data elements are described below for the model previously illustrated in Diagram 1. Details of these data and variables of interest are provided in a series of tables in the Results and Findings chapter.[13] The tables usually display both count and percentage distribution figures. In some cases, statistical significance tests (chi-square or paired comparison tests) were conducted. Results of such statistical testing are reported with the tabular data. The text discusses and interprets the data in each table.

[13]The California Department of Health Services will make the files available to other researchers who are interested in pursuing details of interrelationships not explored by the Project's analysis.

Demographic Data--Data collected in this area included:

Age-- both the age of the chooser and those of any children in the family unit.

Race--ethnic background of the chooser.

Sex--the sex of the chooser.

Marital Status--the marital status of the chooser (head of household).

Educational Level--the highest grade level completed by the chooser.

Language--the language of first choice spoken at home.

Medi-Cal Status--This element defined the Medi-Cal status--"new or old"--of the chooser at the time the dual-choice information was presented. "New" eligibles were those individuals who were not on Medi-Cal at the time of application (intake). "Old" eligibles were the subjects returning for annual redetermination visits.

Health Attitudes--This area represented a broad composite of several attitudinal measures related to the beneficiaries' perceived health status, choices concerning health care providers, and attitudes about the Medi-Cal system. Included were:

Type of Health Care--chooser's usual source of care.

Previous Knowledge of PHP--chooser's knowledge of prepaid health plan.

Central Reason--most salient reason for the chooser's choice.

Most Important Service/Feature--most important aspect that the selected health care delivery system should provide.

Current Health Care Provider--Chooser's family doctor, if any.

Satisfaction with Provider--A five-point scale for rating chooser's satisfaction with current health care provider.

Previous Utilization--This dimension related to the chooser's and his/her family's self-reported health care usage over the last year, including:

Number of Hospitalizations--the number of times the head of household or a family member had been hospitalized during the last year.

Number of Doctor Visits--the number of times the head of household or a family member had seen a doctor during the last year.

Current Medical Needs--whether anyone in the family unit was currently in need of medical attention.

Method--This dimension referred to the seven major marketing methods tested in the demonstration sites, including:

Welfare Office:

a. Audio-visual--the film viewing.

b. Brochure--provision of an explanatory pamphlet with no presentation.

c. State Worker--a verbal presentation made by a Project staff member.

d. Eligibility Worker--a verbal presentation made by a welfare office staff person.

e. HMO Representative--a verbal presentation made by an HMO staff person.

Mail--currently eligible persons were mailed local plan and enrollment information.

Current Method--the HMOs' current methods of enrolling persons, usually door-to-door solicitation.

Comprehension--All enrollees and a sample of fee-for-service group were asked in a telephone interview to respond to a series of true and false statements about prepaid health plans and fee-for-service Medi-Cal. (A pretest of the material demonstrated that the 10 questions used were successful in gauging the beneficiaries' knowledge of the differences.)

Length of Enrollment--This dimension described the beneficiary's length of stay, or months of continuous eligibility, in whatever choice of Medi-Cal that was made.

Local Effects--This dimension is a composite of site and presentation conditions which must be accounted for in the analysis including:

Site--this category is geographical although the data probably reflect other factors, such as history of prepaid health plans in the area, the availability of fee-for-service providers who will accept new Medi-Cal patients, etc.

Presentation setting--characteristics of presentation settings which might affect success of a method include group/individual

intake encounters, waiting room/private viewing booth for film, home visit or office interview for county worker presentation, etc.

Enrollment Choice--The main object of study, enrollment choice, was simply the chooser's selection of fee-for-service or prepaid plan as the primary source of health care.

Data Processing

Marketing-enrollment demonstration files were processed using IBM's generational data groups and the Statistical Analysis System (SAS)[14] software package. Techniques from the Statistical Package for the Social Sciences (SPSS)[15] were also used.

The specific files, described in detail in Appendix I, are available to other researchers through the National Technical Information Services (NTIS) or from the California Department of Health Services upon payment of a copying fee.

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[14] Barr, Goodnight, and Sall. SAS User's Guide, 1979 Edition, (Raleigh N.C.: 1979, SAS Institute).

[15] Nie, et al. Statistical Package for the Social Sciences, 2nd Edition, New York: 1979, McGraw-Hill.

Overview

Offered the opportunity, Medi-Cal beneficiaries go about choosing between and among health care options more or less just as do others in the population--that is, they assimilate certain amounts of information --depending on their current degrees of interest--ask questions if they want more information, make decisions, and give reasons for their choices which are remarkably similar to those found in other choice-making studies.

These findings from the PHRED demonstrations will not be pleasing to those who have been inclined to believe that there is a magic method for Medicaid marketing that will somehow, if it can only be found, suddenly produce a major increase in HMO enrollments. However, the results are reassuring to those who put their faith in a more positive proposition: that program beneficiaries, offered an objective dual choice among options, will choose capitated systems in sufficient numbers to ensure viability for a prepaid Medicaid program.

Very generally stated, then, PHRED demonstrated that the giving of information, without pressure to enroll in an HMO, produced sufficient enrollments, at a reasonable cost per enrollment, to produce a cost-effective expansion of the program in California if such methods were universally adopted. The tests for comprehension of information which compared door-to-door solicitation methods with the methods demonstrated in the welfare office indicated better understandings of the meaning of enrollment resulted from the latter. The final dimension of evaluation, retention of enrollment in the HMO, similarly was encouraging, although data were very limited.

Throughout its more than one year of active demonstrations, PHRED collected data on the results of choices offered to more than 75,000 Medi-Cal beneficiaries. Even subtracting the large number of nonresponding subjects in the mail demonstration, the records on individual choice-makers total more than 31,000. In addition to choice and basic demographic information, a large number of the records encompass data from at least two (for the control method) and three (for mailing and welfare office choices) survey instruments. Information from the Department's eligibility history file is appended to many of the records. Results of a satisfaction survey are also available to compare the opinions of respondents enrolled through the welfare office methods to samples of members of all plans recently surveyed by the Project, using the same survey instrument. In other words, there is an enormous amount of information. Making sense of it and imposing an order on the reporting of the findings have been major projects in themselves. The solution selected is based on the original questions of the demonstration. They are not answered in order, but grouped into subchapters on choice, characteristics of choosers, and other evaluation factors (cost, comprehension, satisfaction, and retention). Acceptability of methods to the demonstration participants is also reported, briefly in this section, and, through the results of a survey, fully in Appendix J.

Cautionary Note

Throughout this section, comments are made on the validity of the data and their statistical significance (or lack thereof). As will be seen, there is much interesting information, but problems of sampling, data collection, and data analysis have made it impossible in some instances to do more than describe results without the confidence to draw any inferences. It must be recognized that what are reported here are the results of a demonstration--not a clinically-controlled research project. It was not feasible, for financial and practical reasons, to

draw a sample of all Medi-Cal beneficiaries and applicants throughout the state and offer them a dual choice according to a rigid design. (The demographic charactertistics of the sample are compared to those of the general Medi-Cal population in Exhibit 3.) Nor was it possible to include every health plan in the demonstration. Finally, by making the welfare office service area the area of analysis, we limited the marketability of the health plans, since in several instances (most notably in Los Angeles) the offices in which the county social services departments agreed to locate demonstrations were not locations in which the health plans were necessarily convenient choices, although they were within their service areas. Overall, these factors evened out to a great degree, but we cannot say that we are dealing with a completely representative sample of anything--Medi-Cal beneficiaries, social services offices, health plans, or marketing areas. Neither can we explain completely all the choice-making behavior we observed, although we report it in some detail.

Choices

Table 1 gives an overview of the variety of percentages of welfare office choices for HMO enrollment, by method and by site. These data are also shown graphically in Illustrations 2 and 3. Sample size varied, with the Oakland office (in which the demonstrations included all applicants for assistance in the office's group intake screening meetings) accounting for nearly 40 percent of all choosers. At the other extreme, East Valley had less than the desired minimum of 100 encounters per method. As a rule of thumb, differences of 5 percent or more in the HMO choice rate resulting from each presentation method were considered meaningful. Such differences were found at each site, although, in some cases, the number of choices is too small to draw conclusions. The averages of all sites, by method, were closer, suggesting the importance of suiting a method to the particular characteristics of its presentation locale. Site, as a variable for this analysis, was taken to include the influence of all associated factors--demographic,

Exhibit 3
Profile of Marketing Enrollment Demonstration Sample
Compared to AFDC Population Characteristics

	Marketing Enrollment Sample Demonstration	AFDC Population
Education Level:	60.5%, 11 or 12 years schooling	73%, 11 or 12 years schooling
Ethnicity:	46.83%, black 38.82%, white	30%, black 66%, white
Age:	49%, between ages of 20 and 31	43%, between ages of 20 and 31
Number of Children:	55%, one child 27%, two children	40%, one child 26%, two children
Sex:	92%, female 8%, male	87%, female 13%, male

Derived from Aid to Families with Dependent Children: Social and Economic Characteristics of Families Receiving Aid during March 1977. Statistical Service Bureau, Department of Social Services, State of California.

Table 1
Distribution of Choices by Welfare Office Site and Method

Site/ Health Care Choice	Brochure		Eligibility Worker		HMO Representative		Film		State Worker		Total Presentations	
	N	%	N	%	N	%	N	%	N	%	N	%
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
East Valley	28		87		31		5		274		425	
FFS	24	86	85	98	19	61	2	40	197	72	327	77
HMO	4	14	2	2	12	39	3	60	77	28	98	23
Florence	148		127		77		172		194		718	
FFS	136	92	121	95	70	91	148	86	165	85	640	89
HMO	12	8	6	5	7	9	24	14	29	15	78	11
Oakland	1080		690		637		437		165		3009	
FFS	989	92	590	86	448	70	386	88	147	89	2560	85
HMO	91	8	100	15	189	30	51	12	18	11	449	15
Pittsburg	204		202		525		175		149		1255	
FFS	165	81	179	89	376	72	140	80	129	87	989	79
HMO	39	19	23	11	149	28	35	20	20	13	266	21
Richmond	307		154		180		67		3 *		711	
FFS	296	96	134	87	154	86	61	91	3	100	648	91
HMO	11	4	20	13	26	14	6	9	0	0	63	9
Sacramento	142		3*		187		138		236		706	
FFS	113	80	1	33	129	69	104	75	136	58	483	68
HMO	29	20	2	67	58	31	34	25	100	42	223	32
West Orange	186		138		33		228		225		810	
FFS	154	83	124	90	29	88	185	81	195	87	687	85
HMO	32	17	14	10	4	12	43	19	30	13	123	15
Total	2095		1401		1670		1222		1246		7634	100
FFS	1877	90	1234	88	1225	73	1076	84	972	78	6334	83
HMO	218	10	167	12	445	27	196	16	274	22	1300	17

*Key e[illegible] errors: method was not demonstrated at site.

Table 1a
Distribution of Choices Excluding the Oakland Office, by Welfare Office Site and Method

Site/ Health Care Choice	Brochure		Eligibility Worker		HMO Representative		Film		State Worker		Total Presentations	
	N	%	N	%	N	%	N	%	N	%	N	%
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
East Valley	28		87		31		5		274		425	
FFS	24	86	85	98	19	61	2	40	197	72	327	77
HMO	4	14	2	2	12	39	3	60	77	28	98	23
Florence	148		127		77		172		194		718	
FFS	136	92	121	95	70	91	148	86	165	85	640	89
HMO	12	8	6	5	7	9	24	14	29	15	78	11
Pittsburg	204		202		525		175		149		1255	
FFS	165	81	179	89	376	72	140	80	129	87	989	79
HMO	39	19	23	11	149	28	35	20	20	13	266	21
Richmond	307		154		180		67		3*		711	
FFS	296	96	134	87	154	86	61	91	3	100	648	91
HMO	11	4	20	13	26	14	6	9	0	0	63	9
Sacramento	142		3*		187		138		236		706	
FFS	113	80	1	33	129	69	104	75	136	58	483	68
HMO	29	20	2	67	58	31	34	25	100	42	223	32
West Orange	186		138		33		228		225		810	
FFS	154	83	124	90	29	88	185	81	195	87	687	85
HMO	32	17	14	10	4	12	43	19	30	13	123	15
Total	1015		711		1033		785		1081		4625	
FFS	888	90	644	91	777	75	640	82	825	76	3774	82
HMO	127	10	67	9	256	25	145	18	256	24	851	18

*Key entry errors: method was not demonstrated at site.

Illustration 2

Percentage of HMO Enrollment Choices
by Welfare Office Method

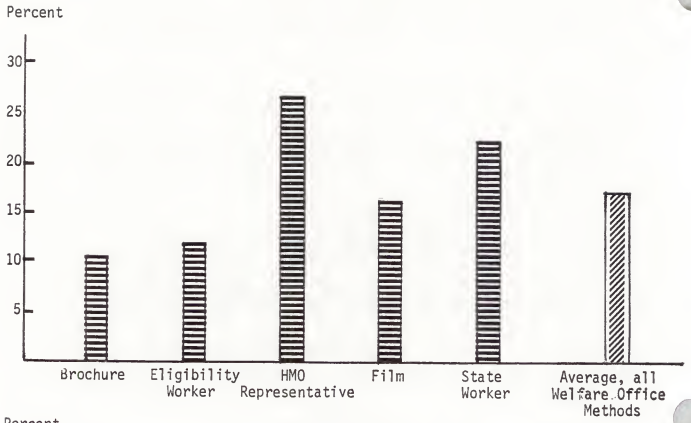
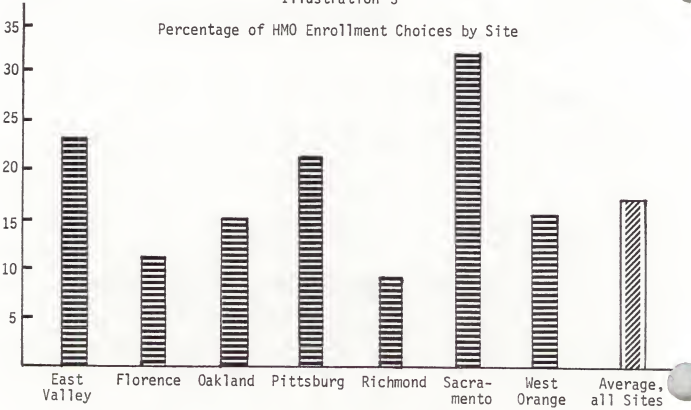


Illustration 3

Percentage of HMO Enrollment Choices by Site



factors--demographic (education, ethnicity, previous Medi-Cal eligibility, etc.,), historical (plan image), and current-day realities (availability of private physicians and other sources of care). Since Oakland generated the largest number of referrals, its influence is heavy in the overall performance of the methods. When Oakland data are removed from the overall averages (Table 1a), the HMO choice rates are similar. Results of paired statistical testing (Z - test) of each method with and without Oakland data did not indicate a significant difference in the HMO choice rate by method.

For comparative purposes, the data presented in Table 1 have been summarized to produce Table 2, which displays the HMO choice rate by method at each site. As can be seen, the site-related rates vary substantially. Earlier in this report, the previous experience of each site with HMOs-PHPs is described. Considering the history, it is not surprising that the results of dual choice-making were lowest in generating HMO enrollment in Richmond and Florence.

In Sacramento, where the HMO choice rate was highest overall, a new health plan was received generally without stigma by the welfare workers and the beneficiary community. However, Sacramento did not demonstrate the eligibility worker method which was the second least productive method in generating HMO choice. Thus, the HMO choice rate for Sacramento may be higher than if all five welfare office methods had been presented. (County social services department administrators were adamant in their refusal to allow their workers to participate in this aspect of the demonstration, despite pleas from the Project that it would create just such a bias.)

In Table 3, the choices recorded for the welfare office demonstration methods are compared to the results of the other demonstration method

Table 2

Percentage of HMO Enrollment Choices
by Welfare Office Method, by Site

Site	Method					All Methods
	Brochure	Elig. Worker	HMO Rep.	Film	State Worker	
(1)	(2)	(3)	(4)	(5)	(6)	(7)
	%	%	%	%	%	%
E. Valley	14	3	39*	60*	28	23
Florence	8	5	9	14	15	11
Oakland	8	15	30	12	11	15
Pittsburg	19	11	28	20	13	21
Richmond	4	13	14	9	**	9
Sacramento	20	**	31	25	42	32
W. Orange	17	10	12	19	13	15
Average of All Sites	10	12	27	16	22	17

* Indicates percent calculated from small number of observations
** Indicates method not demonstrated at site

(mailing) and the plans' current methods (largely door-to-door solicitation)--the control group data. Some of the inherent differences in the systems begin to become evident, along with the differences in results of the methods. For example, the number of contacts is not applicable for the welfare office methods because all encounters are included in the two choices (HMO and FFS). But in the current method and mailing approach, there are many more contacts than presentations of information (in mailing, contact is assumed to have occurred if a choice card is returned, since there is no way to count the people who read the information but do not respond). Percentages of HMO choices are given both for number of contacts and number of presentations given.

Obviously, this other dimension (the getting of the foot in the door, so to speak) has cost implications as well as the potential for problems in

Table 3
Comparison of Demonstration Methods with Control Method

Comparison Factor	Welfare Office Method					Mailing Method	Current Method
	Brochure	Eligibility Worker	HMO Representative	Film	State Worker		
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
N of contacts	N/A	N/A	N/A	N/A	N/A	61,342	6,490
N of presentations given/mailing cards returned	2,095	1,401	1,670	1,222	1,246	17,267*	1,186 (18% of all contacts)
% presentations given/cards returned	N/A	N/A	N/A	N/A	N/A	28%	18%
N of HMO choices	218	167	445	196	274	303*	664
N of FFS choices	1,877	1,234	1,225	1,026	972	11,713	413
HMO choices as % of total presentations with clear choices	10.4%	11.9%	26.6%	16.0%	21.9%	2.5% (.49% of all contacts)	56% (10% of all contacts)
N of enrollments	595	462	1,294	561	768	667	1,388
N of family per HMO choices	2.72	2.76	2.91	2.86	2.80	2.2	2.09

*Includes those self-enrolling and those requesting more information; 5251 did not indicate a clear choice between HMO and FFS.

the need to enhance the information in order to get attention. In the welfare office, the choice-making, in effect, was required and attention was focused by the system on the need to make a choice.

The experience of all three methods will be discussed in much greater detail below, but it is possible here to make several statements of comparison:

- Of the total sample of 7,634 choicemakers in the welfare office, 1,300, or 17 percent, enrolled in HMOs.

- Of the 6,490 individuals contacted by the health plans' marketing representatives, using their current methods, 664 enrolled--about 10 percent of the total number contacted, but 56 percent of those who agreed to a presentation of information.

- Of the 61,342 beneficiaries sent a mailing of information and the invitation to enroll or get more information about enrollment, only 0.49 percent accepted the invitation--2.5 percent of those returning with discernable choices.

- More people (average: 2.83 per choice) were chosen-for (the last line of the chart) in the welfare offices than by either the current method (2.09) or the mailing approach (2.20) which both allow enrollment of individuals in the non-family assistance, one-person only cases.

The balance of this section deals with the choice ratios for each method demonstrated. The welfare office data are presented first, with the results of the five presentation media; then the mailing method; and, finally, the control method for the marketing experiments, the results of the marketing methods currently used by the health plans (usually door-to-door solicitation). Where possible, comparisons are made and comments made on their validity.

Welfare office methods

Within the welfare offices, the dual-choice methods produced enrollments at a rate greater than the 5 to 10 percent projected, in fact, almost equal to the percentage of all Californians enrolled in HMOs. The percentage and number of choices[16] by method are summarized below from Table 1.

Table 4a:
HMO Choices
By Method of Presentation

Method (1)	Number of Presentations (2)	Choice (3) N	Choice (4) (%)
Brochure	2,095	218	(10.4)
Elig. Worker	1,401	167	(11.9)
HMO Rep.	1,670	445	(26.6)
Film	1,222	196	(16.0)
State Worker	1,246	274	(22.0)
Total	7,634	1,300	(17.0)

(Totals may not correspond to other tables due to missing cells in source tables.)

Comments on each medium follow, with site variation reported (again from Table 1).

[16]The table and all the data in this report deal with choices for enrollment, not with actual enrollments. That is, we report on the decisions made after the presentation, not on whether the individual ended up on the health plan's rolls. Problems with tracing individuals through the State's eligibility data files and, especially, lack of follow-up data from participating health plans made it impossible to report on those who chose, made it through eligibility determination, and were in an enrolled status. It is assumed that there is no bias in the eligibility factor and that the choice rate will be an accurate predictor of the enrollment rate, as a percentage of all eligible choosers.

Brochure

Table 4b:
HMO Choices Resulting from Brochure
Method, by Site

Site	Presentations	Choices	
		N	%
East Valley	23	4	(17.4)
Florence	148	12	(8.1)
Oakland	1080	91	(8.4)
Pittsburg	204	39	(19.1)
Richmond	307	11	(3.6)
Sacramento	142	29	(20.4)
West Orange	186	32	(17.2)
Total	2095	218	(10.4)

Like all the methods, the brochure-only results varied greatly by site, indicating the significance of site as a predictor of choice. As will be seen in the discussion of site below, the choice rates for all methods within a site have a smaller range than the choice rates for a particular method across all sites. This method and the film method (the two nonpersonal media) also varied greatly in their actualization. The Project attempted to control the natural impulse of information givers in the welfare offices who were asked questions about the information given. They were requested to limit responses to reiterations, in different words, if necessary, rather than interpretations of what the choice might mean to the individual, but this degree of restraint was difficult to achieve.

(Caution is advised in extrapolating from this table. Simply passing out a brochure may not achieve a replication of the 10 percent choice. But using the method and answering a few questions should, in similar settings. It should also be recognized that the tendency to go beyond the presentation material was no greater with this method than any of the others. The impact of the Hawthorne effect of heightened awareness and interest in the function should also be considered. It is safe to

assume that there was some degree of such effect in these demonstrations; however, it may have been balanced to some degree by the negative attitudes of most of the California welfare workers.)

Eligibility Worker

Table 4c:
HMO Choices Resulting from
Eligibility Worker Method, by Site

Site	Presentations	Choices	
		N	(%)
East Valley	87	2	(2.3)
Florence	127	6	(4.7)
Oakland	690	100	(14.5)
Pittsburg	202	23	(11.4)
Richmond	154	20	(13.0)
Sacramento*	(n/a)	(n/a)	--
West Orange	138	14	(10.1)
Total	1401	167	(11.9)

*This method was not tested in Sacramento at the request of county social services department management.

Eligibility worker presentations were expected to produce less enrollments than any other method except the unassisted brochure method. The results of this study confirm this expectation. The range of differences at the site level is not as great as with some of the other methods, indicating perhaps that the general hostility of the eligibility workers toward adding this new function to their current list of tasks was a more significant influence than their local experience with the health plans. (See Appendix J for results of the comparison of the acceptability of the methods; as might be imagined, eligibility worker presentations were least acceptable to eligibility workers.) Or, this relatively low and rather consistent rate may reflect dilution of the power of the presentation when it is buried among all the other parts of the eligibility process rather than clearly set aside as it was for the other methods.

Table 4d:
HMO Choices Resulting from
HMO Representative Method, by Site

Site	Presentations	Choices	
		N	(%)
East Valley	31	12	(38.7)
Florence	77	7	(9.0)
Oakland	637	189	(29.7)
Pittsburg	525	149	(28.4)
Richmond	180	26	(14.4)
Sacramento	187	58	(31.0)
West Orange	33	4	(12.0)
Total	1670	445	(26.7)

Comparison of the sites for the results of the HMO representative method is limited by the great variation in numbers of presentations made. Because of the small number of cases in some sites, results may not be compared for statistical significance, although they contribute to the overall totals. The sites with competing HMOs produced the fewest numbers of presentations largely because of problems with HMOs scheduling the rotation of responsibility for making them. The southern California sites each had at least three HMO choices (Florence had four), although the number of potential presenters was reduced by one in each instance, since Kaiser declined to station a representative onsite.

It was not possible to have all plans represented at all times in the welfare offices because of space problems and because the HMOs did not wish to have one of their staff members tied up for a marketing approach that was likely to be less productive than going door-to-door--given the small size of the total sample and the competition. Instead, schedules were devised for rotation of the HMOs' representatives. Plan performance in meeting the schedules was generally poor and that of eligibility workers in making referrals to the representatives even poorer. The workers often "forgot" or "didn't know he/she was in today," etc. The

number of presentations was further reduced by the termination of two contracts during the demonstrations (North East Valley in East Valley, and HMO Concepts in West Orange).

The data from the two sites in Contra Costa County--Richmond and Pittsburg--should be examined with the knowledge that this method closely paralleled the way in which the health plan (Contra Costa Health Plan, sponsored by the County itself) usually marketed to Medicaid beneficiaries. The plan's usual contact was with new and continuing eligibility applicants who were asked by their workers if they were interested in hearing about the health plan and referred if they were. The plan had enrollers present in all welfare offices on an on-going basis and the chief difference of the demonstration was that the eligibility worker was to refer all clients without screening for interest. The number of presentations was further inflated because the County decided to add the mandatory information-giving about the Early Preventive Screening and Diagnostic Testing program (EPSDT) to the HMO presentation.

Oakland, again, differed from the other sites in that presentations were made to all applicants (rather than a sample) during the intake group information-giving. Thus, there is no "normal" site, except for Sacramento. Here the HMO choice was new to the area and the plan did rather well.

Film

Table 4e:
HMO Choices Resulting from the Film Method, by Site

Site	Presentations	Choices	
		N	(%)
East Valley	5	3	(60.0)
Florence	172	24	(13.9)
Oakland	437	51	(11.7)
Pittsburg	175	35	(20.0)
Richmond	67	6	(9.0)
Sacramento	138	34	(24.6)
West Orange	228	43	(18.9)
Total	1,222	196	(16.0)

As noted above, the film was to be presented without any personal information-giving, a constraint that often proved too difficult for professional information-givers. These data should be interpreted with the knowledge that there were questions answered in many instances after the film was shown. (It is important to recall, here as with the brochure method, that this factor--questioning and answering--operated just as much, if not more so, in the personal presentations. Even the Project's own staff had trouble some times in sticking to the script, when a someone was asking for more information in order to make a very important choice. The amount of "noise" in the data is acceptable since it probably reflects rather accurately the way such methods would operate in an actual implementation.)

The film produced some of the most consistent results across sites; it was second only to the eligibility worker method in this regard. This would be expected, since the message was presented in exactly the same

fashion through the same (images of) people in each encounter. All viewers saw and heard the same information, without any confounding questions of literacy. Thus, the variation in results here perhaps may be taken to reflect the true variation in site with all that might encompass (past experience with HMOs, need for accessible medical services, cultural factors that influence acceptance of innovation, and a multitude of other, nonquantifiable variables).

Although some problems were encountered in finding suitable locations within the welfare office to show the film, this consistency of information-giving and of results recommend it as a good basic approach, to be linked with personal question-answering in whatever fashion is best for the site.

State Worker

Table 4f:
HMO Choices Resulting from State Worker Method, by Site

Site	Presentations	Choices (Number/Percent) (N)	(%)
East Valley	274	77	(28.0)
Florence	194	29	(14.9)
Oakland	165	18	(10.9)
Pittsburg	149	20	(13.4)
Richmond	3	0	--
Sacramento	236	100	(42.4)
West Orange	225	30	(13.3)
Total	1,246	274	(22.0)

The state worker method represents the use of a specially-trained individual worker in each office who is charged, as a primary responsibility, with the dual-choice information-giving and enrollment process. The workers in the demonstrations were employees of the Project and were

undoubtedly more motivated in their roles than might be the case in a nondemonstration mode. This is not to say, however, that they were universally pushing the HMO choice. On the contrary, they seemed generally more interested in seeing that the choosers received all the information necessary to make an informed choice.

Each site had a state representative assigned throughout the demonstration. (In some sites there was some initial shuffling as schedules for methods changed.) As in all the personal presentation methods, there is some possibility that these results were affected by the personality and capability of the individual representatives--a variable for which it is difficult to analyse but of which it is important to be aware. The overall experience of this method motivated the State of California's decision to use a specially-trained, dedicated worker in each office for the statewide dual-choice implementation. (Because of funding peculiarities in this state, the workers will be employed by the counties, but paid by the State.)

The "Old"/"New" Issue

One of the major research questions involved an hypothesized difference between the choices of those eligibles who were new to the system, unacquainted with welfare or Medicaid, and those who had been on Medicaid before but would be newly presented with a dual choice while going through an eligibility redetermination process.[17] As noted briefly in the constraints discussion, it was difficult in actual practice to tell the difference between oldtimers and newcomers to the system. Especially in areas that were hard-core poverty locales, the

[17]Eligibility redetermination is required annually for AFDC clients by federal regulation; some states carry out the "face-to-face' process more often.

new applicant was not likely to be innocent of knowledge of Medicaid. In all areas, intake clients were commonly people who had been on aid before, but who had shifted to a pending status because of paperwork problems, or who had temporarily been employed and lost eligibility. In our first definition, "new" meant not having been on aid for the previous six months. When we learned about the real world after the demonstrations started, we changed the meaning to make "new" merely synonymous with intake (or application from someone not currently on aid); "old" describes a redetermination, or continuing, client who comes to the welfare office annually for reaffirmation of eligibility.

With this semantic distinction in mind, it is possible to say that there were some differences between the responses of old and new beneficiaries to the presentation methods. They are displayed in Table 5. There is a difference in the number of clients in each group. The redetermination (old) sample is only about 13 percent of the entire choosers group, and it represents only about 12 percent of the HMO choices. (The applicant's choice rate for HMOs was 17.3 percent, while the rate for redetermination clients was somewhat lower, at 15.8 percent.) The discrepancy in size of the two groups resulted from the difficulties experienced by the Project in imposing the demonstration on the usual redetermination process, which does not operate on a flow basis, as does intake. Instead, clients are scheduled for interviews at their workers' convenience, making it extremely difficult to carry out the rather tightly scheduled demonstration plan. Overall, there is a statistically significant difference between new and old clients in the choice rates for HMOs by method ($\chi^2 = 19.71$, 4 df, $p<.001$). Controlling for method, specific differences in the choice rates between old and new beneficiaries are significant only for the eligibility worker and state worker presentation methods (Table 5-a). This seems to suggest that returning eligibles are less responsive to the personal presentations of

the eligibility worker and the state worker.[18] This interpretation, while somewhat questionable on the basis of sample size, is promising for the implementation of dual choice in the Social Security Administration offices in which eligibility for Medicaid is determined and continued for those who receive SSI/ SSP assistance. If these methods work with people who have been experienced in the system, it might not be necessary to attempt to change the usual function of the SSA workers, now totally related to eligibility verification, to include the "social service" of information-giving.

Table 5
Distribution of HMO Choosers by Old/New Status, by Method

Method	New HMO Choosers N	%	Old HMO Choosers N	%	% Difference (old vs. new)
(1)	(2)	(3)	(4)	(5)	(6)
Brochure	189	10.0%	29	13.4%	+3.4%
Elig. Worker	158	12.4%	9	7.2%	-5.2%
HMO Rep	402	27.6%	43	20.0%	-7.6%
Film	164	15.7%	32	18.0%	+2.3%
State Worker	227	23.5%	47	16.8%	-1.5%
Total	1,140	17.3%	160	15.8%	-1.5%

Table 5-a
Significance Testing: HMO Choosers of New-Old Status, By Method

Method	Z Values HMO Choosers by New Versus Old Status
Brochure	-1.56
Eligibility Worker	1.71
HMO Representative	2.34*
Film	-0.77
State Worker	2.39*
Total	1.18

*Statistical significance indicated at the 5 percent level between the new and old groups.

[18]Because of the small number of redetermination client choices it is not possible to break down the choices by site, by method, and present data with statistically significant differences. Thus, they are presented in the aggregate only.

The Influence of Setting

Another hypothesized influence on the choice rate in the welfare offices was the setting of the presentation--that is, whether the chooser received the information and made the choice alone, as an individual, in a group, or as part of a couple. Results of choices by setting are presented in Table 6, but once again a caution is necessary. Oakland accounted for almost all of the group data, with some group settings reported from Sacramento, Florence, and the other sites. Couples were encountered infrequently, although in greater numbers in the recessionary period of the demonstrations than previous, better economic times.

Table 6
Choice Related to Setting
(Overall Results)

	Setting					
	Individual		Group		Couple	
Choice	N	%	N	%	N	%
(1)	(2)	(3)	(4)	(5)	(6)	(7)
HMO	622	17.7	577	15.5	84	25.5
FFS	2893	82.3	3146	84.5	246	74.5
Total	3515	100.0	3723	100.0	330	100.0

$X^2 = 23.79$ 2df $p<.001$

Table 6-a
Significance Testing: Type of Setting on HMO Choice Rates

Comparison	Z Value HMO Choosers by Specified Type of Setting
Group vs. Individual Setting	2.65*
Group vs. Couple Setting	3.27*
Individual vs. Couple Setting	-4.55*

* Statistical significance indicated at the 1 percent level between the HMO choice rates in the specified settings.

There is a significant difference between the settings in terms of choice rates for HMOs. These differences are statistically significant

in all paired comparisons of the settings (Table 6-a). The markedly higher rate in the couple setting may be due to the particular situation of most clients who presented themselves as couples applying for aid rather than single heads of households. The couples were more likely to be new to the system--often the recently unemployed or people new to the area, unable to find work.

The results by method, presented in Table 7, show some variation. Data are not presented by site; they are confounded because each office

Table 7
Choice Related to Setting from
Welfare Office Method Presentations

Welfare Office Method/Choice	Individual N	(%)	Group N	(%)	Couple N	(%)
(1)	(2)	(3)	(4)	(5)	(6)	(7)
Brochure						
FFS	730	(87.1)	1082	(91.7)	42	(84.0)
HMO	108	(12.9)	98	(8.3)	8	(16.0)
Eligibility Worker						
FFS	580	(91.6)	596	(85.8)	59	(81.9)
HMO	53	(8.4)	99	(14.2)	13	(18.1)
HMO Representative						
FFS	580	(75.6)	578	(71.5)	60	(67.4)
HMO	187	(24.3)	230	(28.5)	29	(32.6)
Film						
FFS	363	(81.6)	611	(85.8)	46	(78.0)
HMO	82	(18.4)	101	(14.2)	13	(22.0)
State Worker						
FFS	640	(76.9)	279	(85.1)	39	(65.0)
HMO	192	(23.1)	49	(14.9)	21	(35.0)
TOTAL						
FFS	2,893	(82.3)	3146	(84.5)	246	(74.5)
HMO	622	(17.7)	577	(15.5)	84	(25.5)

rather consistently used either group or individual presentations and there are insufficient numbers of couples to differentiate between sites.

Results of chi-squared testing indicate a significant difference exists between the three settings in HMO choice rates (x^2=19.75, 2 df, p<.001). The couple setting produced the highest proportion of HMO choices (25 percent), while the individual and group settings produced nearly equal HMO choice rates (17.7 and 15.5 percent, respectively).

The couple setting in the state worker presentation produced the highest HMO choice rate (35 percent); the lowest HMO choice rate resulted from brochures used in a group setting (8 percent).

Mailing method

To no one's surprise, the results of the marketing by mail method were not encouraging: they produced an immediate penetration rate of only about 0.5 percent. However, this result must be evaluated with several factors in mind. The demonstrations provided no way of knowing or estimating the actual longer-term effect of the mailings on enrollment. They may serve to put a State seal of confidence and approval on the health plans and they certainly provide reinforcement for the information provided during the dual choice in the eligibility determination and redetermination processes in the welfare offices. Further, they offer the only possible (at present) method for universal information-giving to the non-AFDC Medi-Cal eligibles (those in the so-called "adult aid" classifications--the elderly, disabled and blind). As noted earlier, only the AFDC eligibles go to the local social services offices; for the others, the Social Security Administration determines eligibility as an adjunct to the SSI-SSP (in California) process.

With these mitigations, we may examine the results without total rejection of the method. Table 8 following tabulates the response and breaks it down by choice.[19] (The information is repeated from Table 3 for reader convenience.)

Table 8
Distribution of Choices Resulting from Mailing Method

Number of packets sent	61,342*
Number of choice cards returned	17,267
Percentage returned	28%
Number indicating clear choice between FFS and HMO**	12,016
Total FFS choices	11,713
Percentage FFS choices	
of all choosers	97.5%
of all addressees	19.1%
Total HMO-related choices***	303
Percentage HMO-related choices***	
of all choosers	2.5%
of all addressees	.5%

* Undelivered returns subtracted from this total
** 5251 returned choice cards were incomplete or choice could not be discerned
*** Includes those self-enrolling and those requesting more information; followup contacts indicated too much confusion between the "enroll in" and "learn more about" HMO options to allow separate analysis.

The table offers several startling statistics: Almost 30 percent of the returned choice cards (9 percent of the total mailing) were incomplete

[19] As described earlier, the mailing response card (example in Appendix D, offered three possibilities: self-enrollment on the card, without any further marketing by the plan, but subject to verification of understanding by the plan (and by the Project for comprehension data collection); request for further information about one or more plans; or a "choice" to continue receiving the usual Medi-Cal card. The latter, of course, was a pseudo choice, cast more as a poll-taking in order to provide some fee-for-service choosers for follow-up. Those who made no choice continued to receive the regular card.

or so incorrectly completed as to make it impossible to discern a choice, indicating a major methodological problem. Also, the overall return rate (28 percent) is phenomenally high for a direct mail marketing effort in which 2-3 percent is a standard response and 10 percent considered very good. This record response rate probably resulted from two factors: the accompanying letter explaining the mailing which asked the beneficiary to return the choice card to register a preference between the options, and the understandable concern of some recipients who, despite reassurances in the letter that they would not lose eligibility by virtue of not returning the card, feared the consequences of nonresponse. (See Appendix B for a copy of the mailing materials.)

This rate of return was unusually high and would probably not be replicated if sent by a health plan without the authority of the State, or if the fee-for-service option were not offered in the psuedo required-choice fashion. Instead, the results would probably look more like the two tiered percentages in Table 8, with approximately 2 to 3 percent interested in enrollment (not an unusually low return for a direct mailing to a general population which has not requested information on a product) and something less than 1 percent actually enrolling. Several pretests of mailing materials by the Project developed similar low percentages of enrollments in Santa Clara and Los Angeles counties--.04 percent and .007 percent, respectively. The initial response rates were somewhat lower for the two pretests, however, at 14 percent from Santa Clara and 11.6 percent for Los Angeles. The lower percentages may reflect the problematic history of the health plans in both counties while the demonstration results include mailings in areas in which health plans were new or had had relatively "clean" histories. (Choices, by site are presented in Table 8a.) In the past, large Foundation-sponsored health plans, which offered most of the practicing physicians in the area, had much better experience with marketing by mail, with more than 20 percent of the addressees enrolling.

The mailing method choice-making and the data describing it were not fully within the control of the Project. We don't know, for instance,

how many of the eligible beneficiaries actually looked at the information packet and decided to make a de facto choice by tossing it out. The system set up to refer requests for information to the health plans was cumbersome, especially in areas in which the beneficiary asked for information about more than one plan, and it was difficult for the plans and the Project to account for every single referral. Table 8b presents data we did collect from telephone followup interviews with a nonrandom sample of the mailing population--those for whom we had telephone numbers. Of these, we were only able to contact 57 percent to verify the final decision. They are not necessarily representative of the final decisions of all the mail respondents.

Table 8a
Mailing Method Choices, by Site

Site	Enroll		Learn About		FFS Card		Unclear Choice		Total Delivered
	N	%	N	%	N	%	N	%	N
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
Orange (N=3,758)	18	(0.5)	196	(5.2)	2,218	(59.0)	1,326	(35.3)	11,790
Sacramento (N=1,709)	3	(0.2)	10	(0.6)	1,071	(62.7)	625	(36.6)	6,731
Pittsburg (N=1,536)	1	(0.1)	9	(0.5)	1,083	(70.5)	443	(28.8)	6,472
Alameda (N=6,493)	5	(0.1)	21	(0.3)	4,465	(68.8)	2,002	(30.8)	6,077
Florence (N=1,483)	8	(0.5)	16	(1.1)	1,083	(73.0)	376	(25.4)	13,030
East Valley (N=1,963)	1	(0.1)	8	(0.4)	1,563	(79.6)	391	(19.9)	7,967
Richmond (N=325)	1	(0.3)	6	(1.8)	230	(70.8)	88	(27.1)	9,275
Total = (N=17,267)	37	(0.2)	266	(1.5)	11,713	(67.8)	5,251	(30.4)	61,342

Table 8b
Mailing Method Follow-up Choices by Decisions

Site	Enroll N	Enroll (%)	Learn About N	Learn About (%)	Card N	Card (%)	Unclear Choice N	Unclear Choice (%)
Orange (N=75)	24	(32.0)	10	(13.3)	0	--	41	(54.7)
Sacramento (N=344)	48	(14.0)	119	(34.6)	12	(3.5)	165	(48.0)
Pittsburg (N=149)	10	(6.7)	58	(38.9)	3	(2.0)	78	(52.3)
Alameda (N=1,130)	60	(5.3)	298	(26.4)	262	(23.2)	510	(45.1)
Florence (N=548)	36	(6.6)	105	(19.2)	261	(47.6)	146	(26.6)
East Valley (N=484)	10	(2.1)	114	(23.6)	211	(43.6)	149	(30.8)
Richmond*	N/A		N/A		N/A		N/A	
Total (N=2,730)	188	(6.9)	704	(25.8)	749	(27.4)	1,089	(39.9)

*No data available.

(Numbers differ from Table 8a because some unclear choices were clarified during telephone interview.)

Finally, Table 8c compares the enrolled populations in the health plans in the five counties of the demonstration with those reached by the Project's telephone followups who had enrolled or still wished to learn more about the HMO(s). The distribution of aid codes for the counties including enrolled and nonenrolled beneficiaries is presented in the last column. The mailing drew interested responses from a disproportionately high number of ATD and OAS eligibles (although they may not have finally enrolled).

Table 8c

Comparison of Enrolled Mail Follow-up
Respondents with the Five-County Beneficiary Population

Aid Code	Mail Follow-Ups* N	%	Plan Population N	%	Total County Eligible
AFDC	180	(49.0)	85,665	(87.5)	68%
AB & ATD**	116	(31.6)	5,965	(6.1)	18%
OAS	71	(19.4)	6,241	(6.4)	14%
Total	367	(100.0)	97,871	(100.0)	

$X^2 = 555.61$ 2df $p<.001$ (Test to validate disproportion of ATD and OAS eligibles interested in or enrolling in HMOs for the number of these individuals in the county population of their aid classifications.)

* Reported entries are only those mail follow-up respondents contacted by telephone.
** AB and ATD categories are combined for X^2 analysis.

Current (control) method

Data from the demonstration of the current method used by the participating health plans to enroll their Medi-Cal members were collected and supplied by the health plans to the Project. (Specifications for plan data collection for this method and all others are included in Appendix K.) As noted in the constraints discussion earlier, lack of interest and some conflicts of interest seemed to have operated--consciously or unconsciously--and the quality and completeness of the reports on the results of the current method are suspect.

It was not practical to follow enrollers around and do a field validity check, but a visual inspection of the data collection instruments ("street sheets") on the encounters shows significant gaps in the requested information, in many instances. Additionally, the number of encounters reported by each plan varied greatly and it is likely that a number occurred during the demonstration period without report. One plan, Kaiser, was unable to supply any information on its current

method, because it was not marketing at all during the demonstration period, but only accepting "walk-ins" in aid categories which were not filled to the contractual limit. Finally, the Project staff made a major error in the data entry phase by not anticipating the need for analysis by demonstration area and not coding the zip code of the current method results that were available for analysis. It should also be recalled that the service areas of the welfare offices which constituted the demonstration sites for all methods, including the mailings and the current methods, may not necessarily have been the primary marketing areas of the participating health plans. That is, the HMOs might have had much different results in areas that were closer to their facilities, where there was less competition, and so forth.

Thus, the current method data are presented with some reservations and without many of the fine comparisons that were planned. It is fortunate, however, that it is possible to verify and validate these data in a gross sense, since we do have the monthly results of total enrollments actually entered into the system by the health plans; for those that are actively marketing, it may be assumed that these results constitute their best efforts to increase their Medi-Cal enrollment in their service areas. The reader is cautioned, in summary, to take the current method data presented from the demonstrations as descriptive, and to have confidence for making comparative inferences only when the report specifically notes that it is justified.

Finally, in order to understand the data, it is necessary to know what method each plan used to market during the demonstration. As mentioned, Kaiser, which was an option in the two Los Angeles sites and in Orange County, did not market and accepted only self-referred applicants. HealthCare, the Sacramento plan, was a new contractor at the time of the demonstrations and concentrated on enrolling its existing fee-for-service patients plus respondents to a mailing which the county welfare department included in cash-grant check envelopes. The Contra Costa

Health Plan, operated by the County Health Department, used a method similar to those employed in the welfare office demonstrations by the Project, except that it depended on referrals from the eligibility workers rather than a mandated choice-making situation. Rockridge, in Alameda County, used a combination of door-to-door solicitation and contacts made as a result of leads (names of friends given by new enrollees). The California Medical Group Health Plan (later acquired by Insurance of North America), CompreCare, Watts, and Northeast Valley Health Plan in the Los Angeles sites, and California Medical Group and HMO Concepts in Orange County all employed a "classic" approach to door-to-door solicitation (cold canvassing, in the vernacular) with occasional referrals of existing fee-for-service patients or referrals of friends.

Table 9 presents the current method data extracted from Table 3.

Table 9

HMO Choices Resulting from Current Method

Number of contacts reported	6490
Number of contacts eligible	2431
Number of presentations given (enrollments attempted)	1186
Number of HMO choices	664
Choices as percent of attempts	56%
Choices as percent of contacts	10%

Some details of plan performance (reported) are presented in Table 10a. The current method, like the mailing method, affords the opportunity to contact individuals in aid classifications other than the AFDC group

and some single enrollments did occur. Aid code breakdowns are not available, but it is safe to assume that many of the single enrollments were in the elderly and disabled categories,[20] although California does allow split choices within AFDC case units, and some single enrollments may represent choices made for one child or adult in the family.

The number chosen-for is a significant cost factor and the results for two of the three major methods demonstrated, with breakdowns for the welfare office media, are given in Table 10 a-b. From the Welfare Office data, (Table 10b), HMO choosers had slightly larger family sizes than did FFS choosers. In the Current Method results (Table 10a), family size of HMO choosers is slightly smaller, reflecting the inclusion of non-AFDC (single eligible) cases in this method. The high number of nonenrolling beneficiaries chosen-for, in column 2 of the current method data may be an artifact, again, of the spotty data collection, or it may indicate that there is a propensity for split choices in the current method, which presents a choice only to those already in the Medi-Cal system. Conceivably, there may be an individual in a family needing access to a provider who enrolls in the HMO while the other family members stay in the fee-for-service system, artificially inflating the data since split choices were not well reported by the plans. Also, of course, enrollers may concentrate on large family groups because their commissions are paid for each individual enrolled, not for contracts signed. (A subjective report of health plan enrollers' performance is presented in the field observations in Appendix G.) In so doing, they may strike out more

[20] The Aid to the Blind population is extremely small and unlikely to enroll in a health plan because of existing provider relationships.

TABLE 10a
NUMBER OF FAMILY MEMBERS ENROLLED IN HMOS BY PLAN
(Current Method)

Plan	Families Not Choosing Enrollment	Number of Family Members Enrolled								Total Number of Individuals Enrolled	Average Family Size Enrolled
		1	2	3	4	5	6	7	8+		
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
CMG, LA	3406 94.1%	88	57	29	15	9	10	1	1	469	2.23
Sacramento	120 62.8%	32	16	12	8	1	0	2	0	144	2.03
CompreCare	97 92.4%	5	0	3	0	0	0	0	0	14	1.75
CMG, Orange	1370 98.4%	17	2	1	0	0	3	0	0	42	1.83
Watts	322 79.3%	33	32	11	4	4	0	0	0	166	1.98
Key Plan	219 50.2%	101	52	31	18	8	3	4	0	456	2.10
NE Valley*	0	0	3	0	0	0	0	0	0	6	2.00
HMO, Orange, LA	146 75.0%	25	7	9	4	1	1	0	0	93	1.98
Rockridge	147 91.9%	0	8	4	0	1	0	0	0	33	2.54
TOTAL	5827	301	177	100	49	24	17	7	1	1430	2.12

*Went out of business shortly after the data collection activities of this project began.

Table 10b

Average Number of Persons Chosen For (Family Size)
Welfare Office Method, by Choice

	HMO Choosers		FFS Choosers		Total	
	Total Individual Beneficiaries	Average Size of Family	Total Individual Beneficiaries	Average Size of Family	Individuals	Average Size of Family
Brochure	595	2.53	4,832	2.52	5,427	2.52
Eligibility Worker	462	2.64	3,221	2.57	3,683	2.58
HMO Representative	1,294	2.69	3,244	2.56	4,538	2.60
Film	561	2.58	2,665	2.51	3,226	2.52
State Worker	768	2.60	2,612	2.60	3,380	2.60
Total	3,680	2.62	16,574	2.55	20,254	2.56

often, but find that risk preferable to spending a long time with an elderly person who represents only one commission and who may finally decline enrollment when she/he understands that existing provider relationships must be abandoned. Finally, we do know that the HMOs did not market on a random basis throughout the service area of the welfare office, but chose to concentrate on streets and neighborhoods they knew to be most productive from past efforts.

Comparison of Demonstration Results to Current Rates

As discussed above, it is not advisable, for a number of reasons, to put confidence in inferences that might be drawn from the comparison of the three major methods compared in this section. That is, to do so would be (1) to decide never to use a mailing method, when in fact it provides general reinforcement for a more effective marketing program and there may be some valid instances in which it is the only approach to use; and (2) to be uncertain what to do about current marketing methods because the data and market area problems make the figures and resulting rates highly suspect for comparison to the better controlled data from the welfare offices.

How then might these results be used to evaluate the potential of their enrollment power? A slightly different dilemma existed when the Project was asked (because of legislative interest) to make cost and savings, as well as enrollment, projections for the implementation of the dual-choice approach six months before the completion of data collection and more than a year before the evaluation analysis. At that time there were not sufficient data from the current method phases of the demonstrations to allow comparison, although it was felt there were sufficient data from the welfare office demonstrations to make predictions of the effect of implemention. The solution used then for comparison purposes is presented in the dual-choice budget change proposal in Appendix H and its approach appears to be the best-suited to the final evaluation as well.

Briefly stated, the analysis assumes that the welfare office sites are generally representative of the types of offices, procedures, and local populations that would be included in a statewide implementation. (In fact, if there is a bias, it might be against the rate of HMO choices, since, as mentioned many times, the HMOs were not always convenient choices for the service areas of the welfare office sites, and convenience, as will be seen in the choice factor discussion, is an important determinant of choice.) Thus, it was deemed possible to use the choice rate in the welfare offices (which did turn out to be slightly less, 17 percent, than the then current 18 percent) and project it to affect all beneficiaries served by all the welfare offices with HMOs in their areas. To compare the health plans' current methods, the best approach seemed to be to use the rate of program growth currently experienced, which, as noted in the budget proposal, was essentially static. As detailed in the calculations in the Appendix, a sizeable (7 percent) increase in numbers of beneficiaries enrolled was expected to result from the substitution of the dual choice in the welfare offices for the plans' current methods. In addition to the effect of the choice rate, the increase was expected to result from the universal choice-making and from the willingness of some health plans not currently enrolling to take Medi-Cal enrollees if they were "delivered" without the need for door-to-door solicitation.[21]

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[21]While the experience of the implementation is not part of the formal evaluation of the demonstration of the dual-choice methods, it may be of interest. To date, and much behind schedule due to sparse staffing, the method (refined from the state worker method in the demonstrations and carried out by county employees), has been implemented in four counties. Alameda, with 11 months experience, has these results: Total presentations 6,283; number of HMO choices, 669; percent, 10.7. After retraining of the workers the rate has increased to 18 percent in most recent months. In the other county with any period of experience, Santa Barbara, over a six month period, 1,002 beneficiaries have been offered a choice and 244 have selected the HMO (24 percent). Most interesting here is the very small number of choosers, only 4, who have terminated enrollment during the 30-day "cooling off" period. The usual loss experienced for this volume of enrollments from door-to-door marketing is estimated to be as high as 73 contracts, during a 30-day "cooling off" period.

The cost dimension is linked with the choice rate as the prime evaluation criteria for the methods demonstrated. The original plan for the evaluation of the data contemplated a full exposition of the links between the two, including the resulting length of stay in enrollment, by method. The cost of the method was to be the numerator and the average length of stay the denominator in a rate determination, since length of stay implies savings over the fee-for-service program. The underlying hypothesis, which was not tested, was based on a belief that better informed enrollees would be more likely to remain in health plans because they would have realistic expectations and thus, less frustrations and less reason to disenroll. As described earlier, the attempt to link the enrollees from each method to the eligibility and enrollment history files did not produce good data and it is not possible to state the denominator of the cost rate equation with enough certainty for this important dimension.

In this analysis, then, the costs collected for the methods are the numerators and the numbers of choosers, the denominators, giving a cost per choice. Even without the added savings of the increased choices for HMOs, there are significant cost differences between all the welfare office methods and the current method, on a per enrollment as well as a per presentation basis.

Sources and Adjustments

The costs of the various methods were gathered in eclectic fashion due to the absence of comparable cost centers. Each method required differing adjustments in an attempt to assure comparability. Three basic sources were used to determine costs: self-reported costs by prepaid health plans for the control (current) method(s); time reported by county workers, state workers, and HMO representatives for the welfare

office methods--multiplied by application of appropriate reimbursement formulae to account for both direct and indirect expenses; and for mass mailing--distribution, postage, and printing charges accrued by the Project during the mailings.

The Project had what was apparently an overly ambitious plan for collecting data from the health plans about their direct and indirect costs in carrying out their current methods of marketing, in the demonstration areas, during the phase of the schedule that called for their participation. The intention was to collect comparable information about cost centers and costs and relate it to the demonstration results from each plan. (The cost reporting form appears in Appendix K.) Again, some of the information had to come from the solicitor (time spent) but despite the cooperation of most of the plans' administrative staffs, it was not possible to collect this information with any degree of certainty.

Instead, the Department's technical assistance contractor, then carrying out a survey of plan marketing practices and perceived problems, was asked to provide baseline data for this evaluation and for the Department's general information, including some cost-per-enrollment questions about the health plans' usual costs. Thus, what we have is self-reported, but not related to the demonstration efforts by the plans. Since demonstration costs, to some extent, would not have been truly representative of usual plan costs anyway, given the problems with the areas as marketplaces, it was felt that using the overall current marketing costs would provide a better comparison, especially since the final comparison of effect of choice rate was also to be by overall marketing results.

It should be noted, however, that in this conversion to self-reported overall costs from the detailed cost items we had hoped to collect, we lost exact comparability since what went into the self-reported overall cost varied from plan to plan. Some plans included only the direct

costs of enroller salary and commission; others included costs of printed materials and marketing management; some apportioned administrative costs to each individual enrollment; the range was $30 to $152 per person enrolled. We used a rather conservative figure, $35 per person enrolled, which in most instances does not appear to include all of the administrative costs of marketing.

Costs are not itemized by site in this report. There were variations but they were not considered meaningful. Instead, aggregate statewide costs were computed. Finally, it was important to adjust for the differences between the current and mailing methods, which market to beneficiaries already eligible for enrollment, and the welfare office methods, which encounter applicants who may never be eligible. Based on experience from the demonstrations, three assumptions regarding ineligibility of HMO choosers were used (Table 11):

1. 30 percent of the Medi-Cal applicants who chose the HMO through the welfare office would be determined ineligible for public assistance and, consequently, would not be enrolled in the HMO.

2. 3 percent of the Medi-Cal beneficiaries who chose the HMO through the control method, door-to-door solicitation, would lose eligibility for public assistance before effective date of enrollment and, therefore, not be enrolled in the HMO.

3. 3 percent of the Medi-Cal beneficiaries who chose the HMO through the mailing method would lose eligibility for public assistance before the date of enrollment and, therefore, not be enrolled in the HMO.

Table 11

Application of Ineligibility Factors to Demonstration Results

Method	Total Number HMO Choices	Ineligibility Factor*	Revised Number of Choices
(1)	(2)	(3)	(4)
Welfare Office			
. Brochure	218	30%	153
. Eligibility Worker	167	30%	117
. HMO Representative	445	30%	311
. Film	196	30%	137
. State Worker	274	30%	192
(Total)	(1,300)	(30%)	(910)
Mail Method	303	3%	294
Current Method	634	3%	615

* Estimated: Actual ineligibility data are not available for a majority of the subjects.

Costs of Methods

The total costs per method, as demonstrated and for the demonstration periods, are depicted in Table 12 (column 3) followed by the cost per choice (column 4).

Table 12
Costs per HMO Choice, by Method

Method	Revised Number of Choices from Table 11	Total Cost	Cost per Choice
(1)	(2)	(3)	(4)
Welfare Office			
. Brochure	153	$ 503	$ 3.29
. Eligibility Worker	117	$ 4,547	$ 38.86
. HMO Representative	311	$ 4,129	$ 13.27
. Film[a]	137	$ 5,681	$ 41.46
. State Worker	192	$ 3,013	$ 15.69
(Total)	(910)	($17,873)	($ 19.64)
Mailing Method	294	$50,948	$173.29
Current Method	615	$43,808	$ 71.23

[a] Costs of the film and equipment were amortized over a ten-year period. This figure also includes the cost of a county worker because an automatic referral system for the film was unattainable during the demonstrations. This cost would be greatly decreased by additional presentations as it alone among the methods has major one-time-only investments in film production and equipment purchase. Thus, if the choice had been presented to ten times as many individuals, the cost per HMO choice (at the same choice rate) would have been only about $4.50.

Two other approaches to viewing costs are important: enrollment cost per person chosen-for (each chooser represented several family members) and cost per presentation regardless of choice. Table 13 depicts the number of chosen-for enrolled, by method, with the ineligibility assumptions applied.

Table 13

Revised Total Enrollment (All Family Members) by Method

Method	Total Enrollment	Ineligibility Factor	Revised Total Enrollment
(1)	(2)	(3)	(4)
Welfare Office			
. Brochure	595	30%	416
. Eligibility Worker	462	30%	323
. HMO Representative	1,294	30%	906
. Film	561	30%	393
. State Worker	768	30%	538
(Total)	(3,680)	(30%)	(2,576)
Mailing Method	667	3%	647
Current Method	1,290	3%	1,251

Table 14 displays the cost-per-enrollment figures for all methods.

Table 14

Cost per Enrollment, by Method of Enrollment

Method	Revised Total Enrollment	Total Cost per Method	Cost per Enrollment
(1)	(2)	(3)	(4)
Welfare Office			
. Brochure	416	$ 503	$ 1.21
. Eligibility Worker	323	$ 4,547	$14.07
. HMO Representative	906	$ 4,129	$ 4.55
. Film[a]	393	$ 5,681	$14.45
. State Worker	538	$ 3,013	$ 5.60
(Total Welfare Office)	(2,576)	($17,873)	($6.94)
Mail	647	$50,948	$78.74
Current Method	1,251	$43,808	$35.01

[a] Costs of the film and equipment were amortized over a ten-year period. This figure also includes the cost of a county worker because an automatic referral system for the film was unattainable during the demonstrations. This cost would be greatly decreased by additional presentations as it alone among the methods has major one-time-only investments (film production and equipment purchase). Thus, if the choice had been presented to ten times as many individuals, the cost per HMO enrollment (at the same choice rate) would have been only about $1.50.

Costs of Presentations

Costs for each presentation of information, by method, are presented in Table 15.

Table 15

Cost per Presentation, by Method

Method	Number of Presentations	Total Cost per Method	Cost per Presentation
(1)	(2)	(3)	(4)
Welfare Office			
. Brochure	2,095	$ 503	$ .24
. Eligibility Worker	1,401	$ 4,547	$ 3.24
. HMO Representative	1,671	$ 4,129	$ 2.47
. Film[a]	1,222	$ 5,681	$ 4.65
. State Worker	1,248	$ 3,013	$ 2.41
(Total)	(7,637)	($17,873)	($ 2.34)
Mailing Method	17,267[a]	$50,948	$ 2.95
Current Method	1,186	$43,808	$36.93

[a] The count for the mail method includes only those who responded to the mailing; the cost per presentation is thus inflated by the unknown factor of non-response.

Although mailing costs were extremely low on a cost per presentation basis ($2.95), very few enrollments were generated. Mailing is the most expensive method on a cost-per-enrollment basis ($78.74). The least expensive methods appear in the welfare office with significant variance from the brochure method ($1.21 per enrollment) to the film method ($14.45 per enrollment, without allowance for amortization over a larger number of choosers).

Although the first two criteria discussed--choice and cost--attract the most interest in the evaluation of the methods demonstrated, the comprehension dimension is of more than academic interest. The hypothesis that relates comprehension to development of appropriate expectations (and, by extension, to a longer period of enrollment) has been proven in other studies, most notably by Bice (1973). Additionally, it is commonsensical to expect that people who understand what they are getting into when they join a health plan will be more likely to be satisfied with their experiences and thus less likely to disenroll voluntarily.*

No evidence related to retention of enrollment is presented here; however, there are some interesting results when the comprehension scores of those choosing fee-of-service cards are compared with the HMO choosers, for the three major methods. HMO choosers in the welfare office showed a significantly higher comprehension score, for all media, over the FFS choosers. Just the opposite was true for the current method. For the latter, HMO choosers were only about half as likely to have a high score when compared to those who decided to remain in the FFS system after listening to an enrollment presentation by a plan enroller. Scores from those responding to the mailings were higher for the HMO choosers, although not as high as the welfare office. Although the numbers are small, and it is not possible to generalize, these results are striking--especially when they are considered in knowledge of the then (no longer) required telephone verification of every enrollment. During the verifications, the HMO's staff members were required to ascertain the understanding of key points of the enrollment presentation before the enrollment contract could be submitted and

*Beyond common sense, this expectation was confirmed in one of the PHRED satisfaction survey demonstrations when people who reported that their enrollers had misled them were more likely to report an intention to disenroll. (PHRED Project, Dissatisfaction in California HMOs, 1981)

accepted by the State. (Verification questions covered the same information as the comprehension test given by the Project in its follow-up telephone interviews. The latter were given with some time delay, while the former usually occurred immediately after the presentation while the enroller was still in the home. In other words, the group with the lower comprehension scores on the Project's follow-up test had already "passed" the same kind of test in order to enroll in the health plan.)

To understand the scores it is necessary to know something about the test. Nine true-false questions were asked, with a randomly alternating pattern of correct responses. (See Phone Follow-up Information Form in Appendix D.) It was possible to achieve a score of anywhere from 0 to 9 correct. For ease of analysis and reporting, the scores were compressed into four categories: 0 correct, and low (1-3) correct), medium (4-6 correct), and high (7-9 correct). The testing followed the presentation by a period of some weeks, in order to assess retention of information as well as comprehension. The mean periods between the presentation and the test were 67 days for the welfare office choosers; 39 days for the current method; and 107 days for the mailing method.

The following tables present the comprehension data, comparing the results of fee-for-service and HMO choices within the welfare office (Table 16) and the three major methods with each other, with the welfare office methods aggregated (Table 17).

Table 16 shows comprehension of the welfare office presentations to be generally good. High comprehension scores comprise over 50 percent of the total scores. There is a significant difference between the HMO and FFS choosers in their comprehension scores ($x^2 = 118.09$, 3df $p<.001$). Comprehension is higher for the HMO choosers. In Table 17 the same relationship is apparent, overall. HMO choosers have significantly higher comprehension scores ($x^2 = 54.7$, 3df, $p<.001$) except for the current method results, in which the FFS choosers attained higher scores than did the HMO choosers.

Table 16

Comprehension Scores by Choice from Welfare Office Presentations

Welfare Office Method/Choice	Zero Correct N	Zero Correct %	Low N	Low %	Medium N	Medium %	High N	High %	Total N	Total %
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
Brochure										
HMO	2	(2.4)	9	(10.6)	24	(28.2)	50	(58.8)	85	(100.0)
FFS	9	(3.3)	46	(17.1)	99	(36.8)	115	(42.8)	269	(100.0)
Eligibility Worker										
HMO	0	--	3	(4.4)	15	(22.1)	50	(73.5)	68	(100.0)
FFS	0	--	28	(17.4)	46	(28.6)	87	(54.0)	161	(100.0)
HMO Representative										
HMO	7	(4.5)	13	(8.3)	42	(26.9)	94	(60.3)	156	(100.0)
FFS	4	(2.2)	21	(11.5)	62	(33.9)	96	(52.5)	183	(100.0)
Film										
HMO	1	(1.1)	7	(8.0)	25	(28.7)	54	(62.1)	87	(100.0)
FFS	0	--	12	(12.5)	31	(32.3)	53	(55.2)	96	(100.0)
State Worker										
HMO	0	--	10	(9.2)	32	(29.4)	67	(61.5)	109	(100.0)
FFS	3	(2.0)	21	(14.3)	52	(35.4)	71	(48.3)	147	(100.0)
Total HMO	10	(2.0)	42	(8.3)	138	(27.3)	315	(62.4)	505	(100.0)
FFS	16	(1.9)	128	(15.0)	290	(33.9)	422	(49.3)	856	(100.0)

Table 17

Comprehension Scores by Method by Choice

Method	Zero Correct N	%	Low N	%	Medium N	%	High N	%	Total N	%
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)
Welfare Office*										
HMO	11	(2.1)	43	(8.1)	149	(28.2)	325	(61.6)	528	(100.0)
FFS	16	(1.8)	143	(15.17	310	(34.0)	444	(48.6)	913	(100.0)
Mailing Method										
HMO	1	(5.3)	4	(21.1)	4	(21.1)	10	(52.6)	19	(100.0)
FFS	39	(14.0)	94	(33.8)	88	(31.7)	57	(20.5)	278	(100.0)
Current Method										
HMO	0	--	6	(18.2)	15	(45.5)	12	(36.4)	33	(100.0)
FFS	0	--	2	(3.1)	20	(31.3)	42	(65.6)	64	(100.0)
Total HMO	12	(2.1)	53	(9.1)	168	(29.0)	347	(59.8)	580	(100.0)
FFS	55	(4.4)	239	(19.0)	418	(33.3)	543	(43.3)	1255	(100.0)

*Includes some data missing from Table 16, i.e., those choices for which the presentation method was not known.

Although further study is needed to confirm the major differences between comphrension scores for the welfare office method as compared to mail and current methods, some speculation may be risked. Both groups of welfare office choosers, and the HMO choosers in the mailing method, were better informed (as measured by individuals in the high scoring group), than those who chose the HMO after the current method presentations. The fee-for-service choosers in the current method group seemed to know more about the Medi-Cal options than any of the other groups. This may suggest that the information presented in the welfare offices was presented more comphehensibly, or merely that the test measured what was presented in the welfare office and not what was presented by the current method enrollers. Since the information tested for is essential to understanding the meaning of enrollment (lock-in features, need to give up current doctor, etc.), either interpretation suggests some possible deficiencies in the current method's information-giving.

The higher level of comprehension of HMO choosers, which held true across all the welfare office methods, may be related to the concentration which is focused on an innovation by those who are interested in making a change. That is, the person who was not interested in enrolling in a prepaid health plan probably did not listen as well as the beneficiary leaning toward, or open to, enrollment. Or, the fee-for-service choosers may simply have put the information out of their heads since it was concerned with PHP enrollment and thus not relevant to their choice.

The rather low comprehension scores resulting from the mail method are perhaps even easier to understand. The scores are from people who had no direct opportunity[22] to ask questions about the information contained in their mailing packets. They could best be compared to the results from the brochure-only method in the welfare office, were it not

[22] A "no-charge-to-caller" telephone line was made available to mailing recipients and the number appeared in both the cover letter and the informational brochure. Few calls were received.

for at least two factors: many of those who received a brochure in the welfare office also did get some questions answered, and, perhaps more importantly, the samples represent different populations. The mailings went to all eligible beneficiaries in the areas served by the welfare office, including the adult aid classification eligibles who were not in the welfare office sample because their eligibility is determined in Social Security Administration offices.

Because of the need for confidentiality and the public nature of the return postcard which indicated the mail respondent's choice, the aid code of respondents was not collected. It would be technically possible to link the respondent file with the mailing list (for which aid code identification is available) through a code number, but this constituted a major programming task which time did not allow. Instead, we rely on other information collected by the Project and make some rather well-founded assumptions. In the three pretests of the mailing method in which aid code was connected with choice and outcome, the adult aid classification group was much more likely than was the AFDC group to return cards for enrollment or to request more information about the health plan. However, once the interested adult aid recipients understood that it would be necessary to use only plan providers and abandon their existing provider relationships, they often withdrew interest and did not enroll in a percentage proportionate to their representation in the population. AFDC beneficiaries had just the opposite pattern: they were lightly represented among the respondents, but more likely to choose enrollment as a final outcome.

These results suggest that beneficiaries, especially the elderly and disabled, have trouble understanding the marketing message when it is sent by mail; this seems confirmed by the comprehension data available for this group. This may be true for the AFDC category as well--they simply did not respond in most instances in the pretests, while many adult aid people were very interested in what they thought was a better way to get health care through their existing providers.

Even in the mailing method's rather poor comprehension showing, however, the HMO choosers were more likely to give correct answers than the fee-for-service group, perhaps again proving the innovation-interest theory discussed above. With the current method, the results were markedly different. Were the numbers larger, comparisons and theories would be more comfortable. The data do fit two disquieting interpretations: people may have enrolled without understanding because they were overwhelmed by the persuasive abilities of professional salespeople and they simply didn't pay attention to the facts; or the enrollers did not present the facts in comprehensible fashion. There may be any number of possible combinations of these factors acting in each case, of course. The difference in results, whatever its cause, is striking. If the data were sufficiently large, and the expectation/length of enrollment hypothesis could be proven, the cost implications, as well as the toll in human frustration and resulting decline in the program's image, would be of major importance.

Acceptability of Methods

While not related to a major hypothesis in the demonstrations' evaluation, the acceptability of the methods to those affected by them is clearly a practical criterion. Results of a study of opinions of county workers and management and health plan managers are reported in Appendix I. The original plan for evaluation proposed surveying, on a case-study basis, all of the groups involved with the demonstrations: health plans, county welfare staff, state staff, and beneficiaries. The last two groups were not included in the survey for reasons discussed below.

The original plan for acceptability evaluation relied on gathering opinions from advocates and representative organizations, since an individual beneficiary subjected to a method would have no standard of comparison. Welfare rights leaders and other representatives of the beneficiary group did participate in the initial formulation of the demonstrations and an ad hoc group of Medi-Cal consumers was constituted

to review the proposal and the pretest materials. Further discrimination between methods proved difficult for these individuals and groups and they generally were much more interested in "changing the system" than in the fine points of how it was done.

There is, then, no acceptability score for beneficiaries, except perhaps when considered in the negative. During the pretests and the negotiations with the county demonstration sites, which took over a year and in which beneficiary representatives were involved as advisors; during the entire data collection period in seven welfare offices; and in hearings before the Legislative committees which changed the law to implement a dual-choice method and mandate the end of door-to-door solicitation--never was there a protest of anything that the Project's demonstrations suggested or did--perhaps the most valid case study in acceptability. Further, in what may be the most remarkable finding of the Project, the number of beneficiaries in the welfare offices who refused to make a choice was less than 50 out of nearly 8,000--less than .5 percent. In many instances, clients given the presentation in the welfare office volunteered comments which indicated that they welcomed the opportunity to make the decision.

For the state staff, acceptability data is lacking because it became irrelevant. By the time the evaluation phase arrived for the dual-choice methods, the State (Department, Agency, the Governor's Administration, and the Legislature) had decided that the initial experience of the dual-choice methods was sufficient to recommend changing the marketing system. California is already implementing a modification of the dedicated worker method (with a county staff person paid by the State, substituting for the state worker method tested), with some use of the brochure-only method and the film in addition to personal question-answering.

The acceptability scores for the county eligibility workers and managers and the health plan management are presented in Appendix J. Briefly summarized, county workers did not want to have any more tasks imposed upon them, neither did county management, although both groups were (generally) supportive of the concept of dual choice. The health plan managers were in favor of an alternative to the current system--if it could produce viable numbers of enrollments. All, naturally, were critical of the demonstration processses, since they imposed changes and the documentation needs were often seen as onerous.

Profiles of the Choosers

One of the more ambitious proposals for the Project's marketing demonstrations was the compiling of a profile of the Medicaid beneficiary "most likely to enroll," with his/her mirror image, the fee-for-service chooser, also to be described. What is presented in this section is descriptive, only, but it does describe a large number of choosers. There are a number of similarities to findings in the literature on the choice-making of other studied (non-Medicaid) groups. (Comparisons to the literature will be found in the next section.)

Before the data are presented, it may be useful to recall how they were collected. For the welfare office choosers, there were two sources of opportunities to collect information: universally, at the time of choice and, for a sample, the telephone follow-up interviews. For the mailing method, a very limited amount of information was requested on the mailing choice card; the chief source of data was the follow-up interview. For the current method, all choice-related information came from the telephone interview. Table 18 presents information about the telephone follow-up interview process.

Table 18

Telephone Follow-up Interviews

Method of Interest	Number of Method Choices Reported	Number of Completed Interviews	Days between Choice & Interview (Mean)
(1)	(2)	(3)	(4)
Welfare Office	7,634	1,531	67
Mailing	17,267	1,227	107
Current	6,491	594*	39
Total	31,392	3,353	N/A

*Although staff records indicate 594 interviews were completed, computer analysis reports on only 100, indicating a most unfortunate loss of data.

Obviously, there is a bias in the data collection--only those with known telephone numbers potentially could be contacted in uniform fashion and then only if their numbers were currently in service and the chooser was reachable during the (extended) office hours in which the Project staff was available to call. Those unreachable by phone whose responses were especially desired--all those enrolling--were sent follow-up questionnaires and a return envelope for self-interviewing. Response was good, but far from universal.

Demographic data in Tables 19a through 19e are drawn from the universal sample of choosers in the welfare office. (Most of the remaining tables (those with the smaller numbers) result from the follow-up interviews.) In addition to the demographic data and previous HMO knowledge (Table 20), the following data related to utilization and health status are assumed to have an influence on choice: recent use of physician and hospital services (Table 21); having a regular source of care (Table 22); the existence of a "family doctor" relationship (Table 23); satisfaction with current provider (Table 24); importance of maintaining a physician relationship (Table 25); and need for immediate care (Table 26).

Responses to the questions which elicited the responses in the tables listed above were straightforward and required no interpretation by the interviewer. Reasons for choice (presented in Tables 27a and b), however, were coded into classes developed from pretests. Because a number of interviewers were needed for timely contact, there was concern over possible inconsistency of interpretation and coding. For validation, welfare office responses of HMO choosers were recoded and manually tabulated (Table 28), providing some reassurance of consistency. Reasons are collapsed into the summary categories in Table 29a. (Main reasons to choose the fee-for-service system are summarized in Table 29b.) Attitudes and expectations appear in Tables 30a and 30b.

After the tables, there is some narrative discussion of the differences perceived between the groups of choosers, with primary emphasis on the welfare office data set. Comparisons and parallels with other studies of choice-making behavior are also offered where appropriate data are available.

Table 19
Demographic Characteristics of Choosers
from Welfare Office Presentations

Table 19a: Age

Age in Years	HMO Choosers N	HMO Choosers %	FFS Choosers N	FFS Choosers %	Total N	Total %
(1)	(2)	(3)	(4)	(5)	(6)	(7)
18-30	866	(17.1)	4,193	(82.9)	5,059	(100.0)
31-50	382	(17.9)	1,753	(82.1)	2,135	(100.0)
51 and older	26	(13.4)	168	(86.6)	194	(100.0)
Missing data	31	(15.2)	173	(84.8)	204	(100.0)
Total	1,305	(17.2)	6,287	(82.8)	7,592	(100.0)

Table 19b: Ethnicity

Ethnicity	HMO Choosers N	HMO Choosers %	FFS Choosers N	FFS Choosers %	Total N	Total %
(1)	(2)	(3)	(4)	(5)	(6)	(7)
Asian	10	(18.2)	45	(81.8)	55	(100.0)
Black	525	(15.2)	2,931	(84.8)	3,456	(100.0)
Filipino	12	(20.0)	48	(80.0)	60	(100.0)
Hispanic	100	(15.9)	527	(84.1)	627	(100.0)
Native American	36	(21.3)	133	(78.7)	169	(100.0)
White	556	(19.4)	2,307	(80.6)	2,863	(100.0)
Other	22	(16.3)	113	(83.7)	135	(100.0)
Total	1,261	(17.1)	6,104	(82.9)	7,365	(100.0)

Table 19c: Education

Amount of Education	HMO Choosers N	HMO Choosers %	FFS Choosers N	FFS Choosers %	Total N	Total %
(1)	(2)	(3)	(4)	(5)	(6)	(7)
8 years or less	46	(14.2)	278	(85.8)	324	(100.0)
9-12 years	947	(17.2)	4,552	(82.8)	5,499	(100.0)
13 or more years	263	(17.1)	1,278	(82.9)	1,541	(100.0)
Total	1,256	(17.1)	6,108	(82.9)	7,364	(100.0)

Table 19
Demographic Characteristics of Choosers
from Welfare Office Presentations
(Continued)

Table 19d: Marital Status

Marital Status	HMO Choosers N	HMO Choosers %	FFS Choosers N	FFS Choosers %	Total N	Total %
(1)	(2)	(3)	(4)	(5)	(6)	(7)
Married	218	(17.3)	1,041	(82.7)	1,259	(100.0)
Divorced	265	(19.7)	1,081	(80.3)	2,135	(100.0)
Separated	389	(19.7)	1,586	(80.3)	1,975	(100.0)
Widowed	15	(12.6)	104	(87.4)	119	(100.0)
Single	441	(15.5)	2,412	(84.5)	2,853	(100.0)
Other	12	(18.5)	53	(81.5)	65	(100.0)
Total	1,340	(17.6)	6,277	(82.4)	7,617	(100.0)

Table 19e: Number of Children

Number of Children	HMO Choosers N	HMO Choosers %	FFS Choosers N	FFS Choosers %	Total N	Total %
(1)	(2)	(3)	(4)	(5)	(6)	(7)
0	68	(14.3)	406	(85.7)	474	(100.0)
1	667	(16.0)	3,499	(84.0)	4,166	(100.0)
2-3	527	(17.9)	2,411	(82.1)	2,938	(100.0)
4-5	96	(23.1)	319	(76.9)	415	(100.0)
6 or more	11	(16.9)	54	(83.1)	65	(100.0)
Total	1,369	(17.6)	6,401	(82.3)	7,770	(100.0)

Table 20
Previous HMO Knowledge and Experience,
by Method, by Choice

Table 20a: Heard of HMO Before

Method/Choice	Yes N	Yes %	No N	No %	Total N	Total %
Welfare Office						
HMO	231	(42.2)	317	(57.8)	548	(100.0)
FFS	389	(43.0)	516	(57.0)	905	(100.0)
Mailing Method						
HMO	131	(15.6)	710	(84.4)	841	(100.0)
FFS	207	(29.8)	488	(70.2)	695	(100.0)
Current Method						
HMO	17	(48.6)	18	(51.4)	35	(100.0)
FFS	27	(40.9)	39	(59.1)	66	(100.0)

Table 20b: Joined HMO Before

Method/Choice	Yes N	Yes %	No N	No %	Total N	Total %
Welfare Office						
HMO	135	(24.6)	413	(75.4)	548	(100.0)
FFS	167	(18.3)	744	(81.7)	911	(100.0)
Mailing Method						
HMO	58	(7.0)	775	(93.0)	833	(100.0)
FFS	56	(8.0)	644	(92.0)	700	(100.0)
Current Method						
HMO	9	(25.7)	26	(70.3)	35	(100.0)
FFS	13	(19.7)	53	(80.3)	66	(100.0)

Table 21

Utilization Experience During Previous Year,
by Method, by Choice

Table 21a: Number of Doctor Visits of Chooser Last Year

Doctor Visits	Welfare Office				Mailing Method				Current Method			
	HMO		FFS		HMO		FFS		HMO		FFS	
	N	(%)	N	(%)	N	(%)	N	(%)	N	(%)	N	(%)
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
0	129	(22.6)	113	(11.9)	30	(10.9)	32	(7.5)	0	--	15	(23.1)
1 - 4	250	(43.8)	374	(39.3)	77	(28.0)	90	(21.0)	15	(42.9)	22	(33.8)
5 - 10	102	(17.9)	243	(25.6)	75	(27.3)	112	(26.2)	11	(31.4)	18	(27.7)
11 or more	90	(15.8)	221	(23.2)	93	(33.8)	194	(45.3)	9	(25.7)	10	(15.4)
TOTAL	571	(100.0)	951	(100.0)	275	(100.0)	428	(100.0)	35	(100.0)	65	(100.0)

Table 21b: Number of Vists of Others in Household to Doctor in Last Year*

Household Visits to Doctor	Welfare Office				Mailing Method				Current Method			
	HMO		FFS		HMO		FFS		HMO		FFS	
	N	(%)	N	(%)	N	(%)	N	(%)	N	(%)	N	(%)
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
0	76	(13.8)	145	(15.2)	108	(51.2)	193	(50.8)	11	(33.3)	9	(15.8)
1 - 8	351	(63.7)	500	(52.5)	71	(33.6)	89	(23.4)	11	(33.3)	27	(47.4)
9 - 15	86	(15.6)	203	(21.3)	22	(10.4)	55	(14.5)	9	(27.3)	11	(19.3)
16 or more	38	(6.9)	104	(10.9)	10	(4.7)	43	(11.3)	2	(6.1)	10	(17.5)
TOTAL	551	(100.0)	952	(99.9)	211	(99.9)	380	(100.0)	33	(100.0)	57	(100.0)

*Does not include visits of chooser.

Table 21c: Number of Hospitalizations of Choosers Last Year

Hospitalizations	Welfare Office				Mailing Method				Current Method			
	HMO		FFS		HMO		FFS		HMO		FFS	
	N	(%)	N	(%)	N	(%)	N	(%)	N	(%)	N	(%)
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
0	434	(78.0)	714	(74.5)	197	(74.9)	318	(74.1)	21	(60.0)	49	(74.2)
1	101	(18.2)	192	(20.0)	46	(17.5)	87	(20.3)	11	(31.4)	12	(18.2)
2	15	(2.7)	32	(3.3)	11	(4.2)	12	(2.8)	1	(2.9)	3	(4.5)
3 or more	6	(1.1)	21	(2.2)	9	(3.4)	12	(2.8)	2	(5.7)	2	(3.0)
TOTAL	556	(100.0)	959	(100.0)	263	(100.0)	429	(100.0)	35	(100.0)	66	(99.9)

Table 21d: Number of Other Household Member Hospitalizations in Last Year*

Household Hospitalizations	Welfare Office				Mailing Method				Current Method			
	HMO		FFS		HMO		FFS		HMO		FFS	
	N	(%)	N	(%)	N	(%)	N	(%)	N	(%)	N	(%)
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
0	471	(84.7)	849	(88.7)	194	(94.2)	327	(88.1)	27	(79.4	45	(78.9)
1 - 3	78	(14.0)	103	(10.8)	11	(5.3)	39	(10.5)	7	(20.6)	12	(21.1)
3 - 4	4	(0.7)	1	(0.1)	1	(0.5)	5	(1.3)	0	--	0	--
5 or more	3	(0.5)	4	(0.4)	0	--	0	--	0	--	0	--
TOTAL	556	(99.9)	957	(100.0)	206	(100.0)	371	(99.9)	34	(100.0)	57	(100.0)

*Does not include hospitalization of chooser.

Table 23

Existence of Family Doctor Relationship
by Method, by Choice

Method	HMO Choosers				FFS Choosers			
	Yes		No		Yes		No	
	N	%	N	%	N	%	N	%
Welfare Office								
Brochure	41	(60.3)	27	(39.7)	211	(71.8)	83	(28.2)
Elig. Worker	35	(58.3)	25	(41.7)	130	(80.7)	31	(19.3)
HMO Rep.	41	(43.6)	53	(56.4)	145	(77.1)	43	(22.9)
Film	38	(47.5)	42	(52.5)	78	(71.6)	31	(28.4)
State Rep.	50	(54.9)	41	(45.1)	132	(80.0)	33	(20.0)
Total	205	(52.2)	188	(47.8)	696	(75.9)	221	(24.1)
Mailing Method	214	(68.6)	98	(31.4)	441	(85.8)	73	(14.2)
Current Method	32	(88.9)	4	(11.1)	28	(42.4)	38	(57.6)
Total	451	(60.9)	290	(39.1)	1,165	(77.8)	332	(22.2)

Table 22

Regular/Usual Source of Health Care
by Method*, by Choice

Indicator	Welfare Office Methods				Mailing Method			
	HMO		FFS		HMO		FFS	
	N	(%)	N	(%)	N	(%)	N	(%)
Existence of a regular source of health care								
Yes	417	(32.9)	2,625	(43.3)	523	(70.5)	560	(87.5)
No	851	(67.1)	3,439	(56.7)	219	(29.5)	80	(12.5)
Total	1,268	(100.0)	6,064	(100.0)	742	(100.0)	640	(100.0)
Usual source of health care								
Private doctor	308	(29.0)	2,894	(53.9)	391	(61.9)	459	(84.2)
County clinic	190	(17.9)	729	(13.6)	67	(10.6)	33	(6.1)
County hospital	146	(13.7)	603	(11.2)	66	(10.4)	22	(4.0)
Emergency room	185	(17.4)	646	(12.0)	58	(9.2)	7	(1.3)
HMO	126	(11.9)	88	(1.6)	N/A	--	N/A	--
Other	107	(10.1)	412	(7.7)	50	(7.9)	24	(4.4)
Total	1,062	(100.0)	5,372	(100.0)	632	(100.0)	545	(100.0)

*Current method data are unavailable.

Table 24a

Satisfaction with Current Source of Care, by Method, by Choice

Method/Choice	Satisfied N	Satisfied (%)	So-So N	So-So (%)	Dissatisfied N	Dissatisfied (%)	Total N	Total (%)
Welfare Office Methods								
HMO	266	(75)	52	(14.6)	38	(10.7)	356	(100.0)
FFS	833	(89.7)	75	(8.1)	22	(2.3)	930	(100.0)
Mailing Method								
HMO	225	(88.2)	20	(7.8)	10	(3.9)	255	(99.9)
FFS	407	(93.8)	18	(4.1)	9	(2.1)	434	(100.0)
Current Method								
HMO	34	(97.1)	1	(2.9)	0	--	35	(100.0)
FFS	47	(78.3)	9	(15.0)	4	(6.7)	60	(100.0)

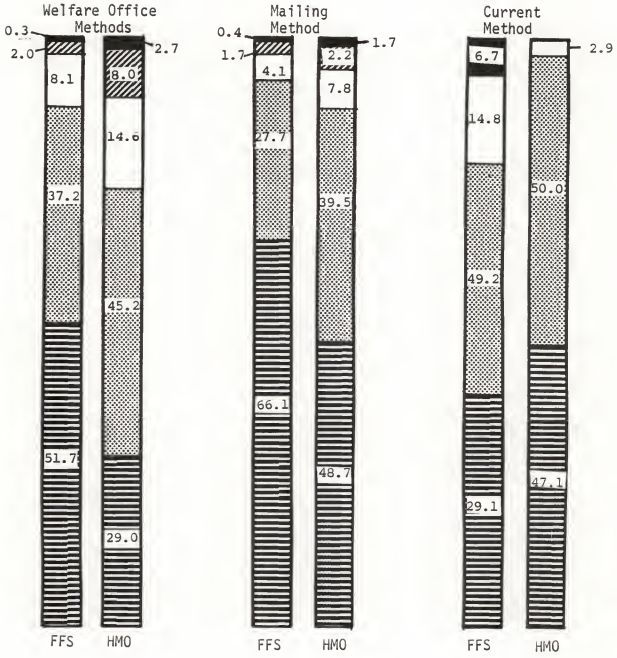
Table 24b

Level of Satisfaction with Current Source of Care
of Welfare Office Method Clients
by Existence of Family Doctor, by Choice

Existence of Family Doctor/Choice	LEVEL OF SATISFACTION											
	Very Satisfied		Satisfied		So-So		Dissatisfied		Very Dissatisfied		Total	
	N	(%)	N	(%)	N	(%)	N	(%)	N	(%)	N	(%)
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)
Those with family doctor												
HMO choosers	87	(39.9)	93	(42.7)	25	(11.5)	9	(4.1)	4	(1.8)	218	(100.0)
FFS choosers	418	(56.6)	262	(35.5)	42	(5.7)	13	(1.8)	3	(0.4)	738	(100.0)
Total	505	(52.8)	355	(37.1)	67	(7.0)	22	(2.3)	7	(0.7)	956	(99.9)
Those without family doctor												
HMO choosers	29	(21.0)	57	(41.3)	27	(19.6)	19	(13.8)	6	(4.3)	138	(100.0)
FFS choosers	71	(37.0)	82	(42.7)	33	(17.2)	6	(3.1)	0	--	192	(100.0)
Total	100	(30.3)	139	(42.1)	60	(18.2)	25	(7.6)	6	(1.8)	330	(100.0)
Total												
HMO choosers	116	(32.6)	150	(42.1)	52	(14.6)	28	(7.9)	10	(2.8)	356	(100.0)
FFS choosers	489	(52.6)	344	(37.0)	75	(8.1)	19	(2.0)	3	(0.3)	930	(100.0)

Illustration 4

Satisfaction with Present Care
Percentage Distribution by Method by Choice



Legend - Satisfaction Level

Very Satisfied
Satisfied
So-So
Dissatisfied
Very Dissatisfied

Table 25

Important to Keep Own Doctor, by Method, by Choice

Method	Yes		No		Total	
	N	%	N	%	N	%
Welfare Office						
HMO	37	(84.1)	7	(15.9)	44	(100.0)
FFS	856	(89.4)	102	(10.6)	958	(100.0)
Mailing						
HMO	187	(83.9)	36	(16.1)	223	(100.0)
FFS	987	(88.9)	123	(11.1)	1,110	(100.0)
Current						
HMO	29	(96.7)	1	(3.3)	30	(100.0)
FFS	8	(100.0)	0	--	8	(100.0)

Table 26

Need Medical Care Now?
by Method, by Choice

Method/Choice	Need Care Now? Yes N	Yes (%)	No N	No (%)	Total N	Total (%)
Welfare Office Methods						
Brochure						
HMO	51	(55.4)	41	(44.6)	92	(100.0)
FFS	123	(43.3)	161	(56.7)	284	(100.0)
Eligibility Worker						
HMO	44	(58.7)	31	(41.3)	75	(100.0)
FFS	71	(45.5)	85	(54.5)	156	(100.0)
HMO Representative						
HMO	79	(50.3)	78	(49.7)	157	(100.0)
FFS	87	(46.3)	101	(53.7)	188	(100.0)
Film						
HMO	50	(53.8)	43	(46.2)	93	(100.0)
FFS	52	(49.1)	54	(50.9)	106	(100.0)
State Worker						
HMO	60	(52.6)	54	(47.4)	114	(100.0)
FFS	59	(39.1)	92	(60.9)	151	(100.0)
Total Welfare Office						
HMO	284	(53.5)	247	(46.5)	531	(100.0)
FFS	392	(44.3)	493	(55.7)	885	(100.0)
Mailing Method						
HMO	150	(55.8)	119	(44.2)	269	(100.0)
FFS	306	(70.7)	127	(29.3)	433	(100.0)
Current Method						
HMO	17	(48.6)	18	(51.4)	35	(100.0)
FFS	37	(56.9)	28	(43.1)	65	(100.0)

Table 27a

Main Reason Given for HMO Choice,
by Method*

Reason**	Welfare Office		Mailing	
	N	(%)	N	(%)
(1)	(2)	(3)	(4)	(5)
More services	90	(19.2)	5	(9.4)
Convenient	83	(17.7)	15	(28.3)
No current source	39	(8.3)	3	(5.7)
Dislike FFS	4	(0.8)	0	-
Try it	14	(3.0)	6	(11.3)
Better service	64	(13.6)	5	(9.4)
Less hassle	22	(4.7)	1	(1.9)
Enrolled before	50	(10.7)	0	-
Other	103	(22.0)	18	(34.0)
Total	469	(100.0)	53	(100.0)

*Current method data not available in sufficient numbers.

**Categories established from responses to open-ended questions during pretests.

Table 27b

Main Reason Given For FFS Choice,
by Method*

Reason**	Welfare Office		Mailing	
	N	(%)	N	(%)
(1)	(2)	(3)	(4)	(5)
PHP too far away	25	(2.6)	1	(0.2)
Established provider	236	(24.9)	137	(30.0)
Use any MD/hospital	79	(8.3)	46	(10.1)
Freedom of choice	96	(10.1)	15	(3.3)
Convenient	79	(8.3)	43	(9.4)
Immediate attention	8	(0.8)	6	(1.3)
Special services	8	(0.8)	2	(0.4)
PHP confusion	42	(4.4)	11	(2.4)
Like FFS	72	(7.6)	34	(7.4)
Other	303	(32.0)	162	(35.4)
Total	948	(99.8)	457	(99.9)

*Current method data not available in sufficient numbers.

**Categories established from responses to open-ended questions during pretests.

Table 28
Reasons for Joining HMO--Validation of Coded Welfare Office Data

Reasons for Selecting HMO:	LOCATION							TOTAL*	
	Pittsburg	Oakland	Florence	Sac.Co.	E.Valley	Orange	Richmond	N	%
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
More services	19	19	6	7	4	4	0	59	(16.5)
Liked plan/previously enrolled	9	8	7	4	9	12	0	49	(13.7)
Seemed better than FFS	14	14	2	7	2	1	1	41	(11.5)
Don't have to look for MD	6	8	2	6	2	5	0	29	(8.1)
Easier	7	5	0	7	1	1	0	21	(5.9)
More convenient	6	9	1	11	5	2	1	35	(9.8)
Everything in one place	4	8	0	3	1	2	1	19	(5.3)
Dissatisfied with private MD	2	2	0	0	0	0	0	4	(1.1)
No current source of Care	3	10	1	4	2	2	2	24	(6.7)
Someone recommended it	2	3	1	2	1	2	0	11	(3.1)
Decided to try it	3	4	1	1	0	0	1	9	(2.5)
Better care	1	1	0	1	0	1	0	4	(1.0)
Pressured to enroll	1	0	1	1	0	2	0	5	(1.4)
Liked the set-up	1	2	1	3	0	0	0	7	(2.0)
Thought she/he had to	1	0	0	0	0	1	0	2	(0.6)
Interviewer suggested	1	4	0	1	0	1	0	7	(2.0)
Location	0	2	0	2	1	2	0	7	(2.0)
Embarrassed to use card	0	1	0	0	0	1	0	2	(0.6)

Table 28 (Continued)

Reasons for Selecting HMO:	L O C A T I O N							TOTAL*	
	Pittsburg	Oakland	Florence	Sac.Co.	E.Valley	Orange	Richmond	N	%
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
Thought it would be good	0	1	1	1	0	1	3	7	(2.0)
Didn't understand	0	0	0	0	0	1	1	2	(0.6)
Afraid of losing Medi-Cal card	1	0	0	0	0	0	0	1	(0.2)
Financial	11	4	0	4	1	4	0	24	(6.7)
Numerous MDs							1	1	(0.2)
Better facilities				1				1	(0.2)
No reason	-	-	-	-	-	-	-	41	(11.5)
Phone Surveys Conducted	86	103	24	64	28	42	11	358	-

*Some respondents provided multiple reasons for joining HMO; each response is tabulated.

Table 29a

Summary Statistics:
Reason HMO Choosers Selected HMO System

Reason	Welfare Office N	Welfare Office (%)	Mailing N	Mailing (%)
(1)	(2)	(3)	(4)	(5)
Service Related	154	(32.4)	10	(15.2)
1. More services				
2. Better services				
Access Related	144	(30.3)	19	(28.8)
1. Convenient				
2. Less hassle				
3. No current source				
Previous Enrollment or Personal Experience	50	(10.5)	0	--
1. Enrolled before				
Change Related	14	(2.9)	6	(9.1)
1. Try it				
Other	114	(23.9)	31	(47.0)
Total	476	(100.0)	66	(100.1)

$x^2 = 29.01$, 3df, $p < .001$

(For x^2 evaluation, the "Change-related" category was combined with the "Other" category.)

Table 29b

Summary Statistics:
Reasons FFS Choosers Selected FFS System

Reason	Welfare Office N	Welfare Office (%)	Mailing N	Mailing (%)
(1)	(2)	(3)	(4)	(5)
Access Related 1. PHP too far 2. Immediate attn.	33	(3.5)	7	(1.5)
Service Related 1. Special services	8	(0.8)	2	(0.4)
Provider Related 1. Established provider 2. Use any MD/hospital 3. Freedom of choice 4. Prefer FFS	483	(50.9)	232	(50.8)
Convenience 1. Convenient	79	(8.3)	43	(9.4)
PHP Confusion	42	(4.4)	11	(2.4)
Other	303	(32.0)	162	(35.4)
Total	948	(99.9)	457	(99.9)

Table 30
Choosers' Attitudes Toward Care
Provided by HMOs Compared to FFS
(Welfare Office Method Data Only)

	HMO Choosers		FFS Choosers		Total	
	N (1)	(%) (2)	N (3)	(%) (4)	N (5)	(%) (6)
Expect HMO care to be:						
Better	786	(66.0)	443	(8.0)	1,229	(18.3)
About the same	363	(30.5)	2,201	(40.0)	2,564	(38.3)
Not as good	42	(3.5)	2,863	(52.0)	2,905	(43.4)
TOTAL	1,191	(100.0)	5,507	(100.0)	6,698	(100.0)

Discussion of Tabular Data

Demographic Characteristics (Table 19)--HMO choice rates in the welfare office demonstrations were similar for the 18-30 and the 31-50 age groups (17.1 and 17.9 percent, respectively). The older group (those 51-64) chose HMOs at a lower rate, 13.4 percent. Ethnicity did seem to be a significant variable in predicting choice: whites chose at a higher rate (19.4 percent) than blacks (15.2 percent) and hispanics (15.9 percent). (Differences are statistically significant at the 95 percent and 90 percent levels, respectively.) Asians and Native Americans also had high choice rates for HMOs, but numbers were too small for significant differences to be shown.* Rates of HMO choice were higher for those with 9 or more years of education (17 percent) while those with 8 years or less were more likely to choose the traditional system.** Differences were also found by marital status. Those who were divorced or separated, and those who were married had higher HMO choice rates than those who described themselves as single; while the small number of widows had the lowest HMO choice rate (12.6 percent). Generally, as the number of children in a family increased, so did the tendency to select an HMO as the source of health care. The highest rate of HMO choice (23 percent) was generated from families with 4-5 children; the lowest rate (14 percent) from those with unborn children.

*Significance should be assumed with caution, however, because of the importance of the site variable. The areas in which the most problems occurred with prepaid health plans in the past were those in which blacks and hispanics were the largest groups in the populations. Whites were more likely to be encountered in the demonstration sites in which the health plan offerings were new and untainted by past scandals.

**The level of education question was the one most likely to be refused an answer, or to be answered with embarrassment. No verification of response was possible.

Previous HMO Knowledge and Experience (Table 20)--Generally, a greater proportion of fee-for-service choosers had previous knowledge of HMOs than did HMO choosers. Only in the current method data did HMO choosers evidence higher proportion of previous HMO knowledge. Previous enrollment in an HMO, however, was more positively related to a choice for HMOs, with about 25 percent of both the welfare office and current method HMO choosers reporting previous membership (not necessarily in the same HMO). Mailing method data for HMO choosers were lower, at 7 percent, with fewer people reporting previous enrollment in both groups.

Utilization Experience (Table 21)--Because choices were made for family units by the great majority of choosers in all methods and by all of the AFDC welfare office choosers, data were reported and analyzed for utilization of both the chooser and family members. Generally, HMO choosers tended to have had fewer doctor visits than fee-for-service choosers, although household utilization was slightly greater, perhaps reflecting the larger family size. Intermethod analysis again revealed differences, with the current method often presenting opposite patterns from the welfare office and the mailing method. Household members of welfare office HMO choosers, on the other hand, reported more visits in the 1 to 8 category and less 0 visits than the fee-for-service choosers. The HMO choosers in the mailing method and the current method had more reports in the 0 visit category than the fee-for-service choosers, with varied patterns in the other categories. Similar distributions were reported for the hospitalization experience of choosers and the other members of their households.

Source of Health Care (Table 22)--All welfare office choosers were asked about their regular/usual source of care. Similar questions were asked of the mailing method choosers on the choice card, but limited responses were available for analysis. (Current method choosers were not asked this question.) In both groups for which data are available, HMO choosers are significantly less likely to have a regular source of health care than fee-for-service choosers (32 percent versus 43 percent

for the welfare office methods and 70 versus 85 percent for mailing method). When the respondents were questioned further and asked to identify their usual souce of health care, again significant differences appear in the data: only 29 percent of the welfare office HMO choosers, versus 54 percent of those who picked the fee-for-service system, said they used a private doctor as their usual source of health care. The percentages for the mailing group are higher but similarly less for the HMO choosers than the fee-for-service group, 62 percent versus 84 percent. For both groups of HMO choosers, the usual source of care was more likely to be a county clinic or an emergency room. A rather surprising 12 percent of the HMO choosers in the welfare office said they were currently getting their care at an HMO, although we do not know whether they were enrolled members or using the HMO on a fee-for-service basis.

Family Doctor Relationship (Table 23)--The final question about source of care concerned the existence of a family doctor relationship. There is not a direct correspondence with the previous question about source of care, since both those seeing a private doctor and those using a county clinic (as well as those using an HMO) or other type of clinic might identify one physician as a family doctor. Interestingly, there is a difference here between the control method and the demonstrated welfare office and mailing methods. Nearly 90 percent of the HMO choosers enrolled by the plans' current practices were willing to abandon their existing provider relationship for enrollment in the plan, while the HMO welfare office choosers (55 percent of whom had a family doctor), and the mailing method HMO choosers (68.6 percent reporting a provider relationship) seemed much more likely to stay with their doctors, by choosing Medi-Cal fee-for-service cards. Analysis by method (aggregating both groups of choosers who had physicians) produces this distribution of individuals with family physicians: welfare office, 70 percent; mailing method, 80 percent; and current method, 58 percent. (These differences at the method level are statistically significant (x^2=9.08, 2 df, $p<.05$.) Overall, 78 percent of the fee-for-service

choosers and 61 percent of the HMO choosers stated they had a family doctor relationship at the time of choice.

Satisfaction with Current Source of Care (Tables 24a and 24b)--Whatever their source of care, HMO choosers in the welfare office and mailing methods were less likely to be satisfied than fee-for-service choosers. Again, current method chooser data reveals a different pattern; the HMO choosers are more satisfied than the fee-for-service group (97 versus 78 percent) and none are dissatisfied, while 7 percent of the fee-for-service choosers said they were dissatisfied. This pattern is similar to that of the existing provider relationship breakdown, in which the current method choosers were more likely to abandon an existing provider relationship than in the welfare office and mailing choices. This group seems either to have been less attached to its current providers, although its satisfaction level was higher, or to have been less understanding that they would have to leave them and to use HMO providers, as their comprehension scores suggest.

When the welfare office method client-data are analyzed for satisfaction, with the existence of a family doctor relationship controlled, it is apparent that those HMO choosers who have a family doctor were much more satisfied with current care. A total of 82.6 were very satisfied and/or satisfied categories, compared to 62.3 percent total for those without a family doctor. Expressed in percentages, almost twice as many of those without a family doctor (42 percent), as those with such a relationship (22 percent), picked an HMO.

Interestingly, regardless of the health care choice made, most individuals surveyed stated they were satisfied with the medical care they received.

Importance of Maintaining Physician Relationships (Table 25)--This question, unfortunately, was worded ambiguously, and it was not possible

to sort out those who had a relationship from those who did not but valued it in absentia. Thus, the responses may be taken to relate to an ideal situation as well as to a current relationship. Again, the inter-method differential pattern holds with the welfare office and mailing method HMO choosers being similarly somewhat less attached (84 and 89 percent) to personal physicians than their respective fee-for-service counterparts, while the current method HMO choosers are somewhat more likely to attach importance to the relationship (97 percent) with 100 percent of the fee-for-service choosers stating the importance of "keeping their own doctors."

Current Need for Medical Care (Table 26)--Responses of choosers in the welfare office methods are similarly clustered, with both groups saying they did need care at rates of 53 and 44 percent. The film and the HMO representative methods enrolled slightly more of those who reported no immediate need for care. About half of the HMO choosers from the mailing method and the current method (56 and 49 percent, respectively) also said they needed care, but more fee-for-service choosers perceived themselves in need of health care (mailing, 71 percent; current method, 57 percent) than in the welfare office in which the fee-for-service group's response range was 39 to 49 percent.

Reasons for HMO and Fee-for-Service Choices (Tables 27a and 27b)--Medicaid beneficiaries choosing the HMO option in the welfare office and mailing methods commonly cited service- and convenience-related reasons as their primary motivations. Even though few disliked the fee-for-service system, the greatest number of respondents from the welfare office methods gave "more services" as their main reason and this category was the second highest for the mailing method. Convenience and better services were the next most important reasons with large percentages in each method. Slightly more than 8 percent of the welfare office choosers reported having no current source of care as their most important choice factor. This reason was given less often by the mailing respondents who were already identified with the Medi-Cal system at

the time of their choice-making and thus more likely to have an established provider relationship. The percentage of those who cited previous enrollment as their reason for choosing an HMO was about 11 percent, suggesting the importance of familiarity with the system. Fee-for-service choosers, on the other hand, were more likely to give reasons related to provider choice as their motivations. Established provider relationship was by far the reason most commonly given by both the welfare office and mailing groups of HMO choosers. Some anti-PHP sentiment was expressed, as was direct preference for the traditional system.

Validation of Reasons for HMO Choice (Table 28)--As described earlier, a content analysis was performed to validate the reasons coded, and to break down the large number of responses recorded as "other." Generally, the categorization in the earlier table was supported and when multiple reasons were given, the interviewer's judgment of which was primary was assumed to be appropriate. Interestingly, about 12 percent of the choosers were unable or unwilling to give any reason for their choice and almost 7 percent cited financial reasons. Since there is no cost for either system and coverage is the same, the financial reason category may include those who appreciate the broader formulary for prescription drugs in the HMOs as well as those who have confused their reason for enrolling in an HMO with their reason for applying for financial aid and Medi-Cal.

Summarization of Reasons for Choices (Tables 29a and 29b)--The main reasons were collapsed into general categories in order to allow statistical testing. Chi-squared evaluation of both the HMO and fee-for-service choosers indicate a significant difference in the choice reasons, when analyzed by mail versus the welfare office method. When the mailing and welfare office methods are combined, analysis of the reasons for fee-for-service versus HMO choice also indicates existence of a significant difference (x^2=512.29, 3 df, p<.001). The summary tables show clearly that HMO choosers are interested in services and

access, while fee-for-service choosers are concerned with maintaining their existing patterns of seeking care, whether from a provider with whom they have established a relationship or from a variety of hospitals and physicians--the "freedom of choice" and "use any doctor or hospital" responses.

Choosers' Attitudes Toward Care (Table 30)--Perceptions of the quality of care provided by HMOs and the fee-for-service system among the welfare office choosers were favorable toward the chosen system for both groups, although there are interesting differences. Thus, although 66 percent of the HMO choosers thought their care would be better than it would have been in the fee-for-service system, 4 percent thought it would not be, but chose it anyway. Similarly, 52 percent of the fee-for-service choosers thought they would be cared for better because HMO care was seen as not as good as fee-for-service, but 8 percent disagreed and thought HMO care was better, despite their choice. Ties to existing provider may explain the divergence for the fee-for-service choosers, while the HMO choosers who thought care would be better in the fee-for-service system may have been unable to find a suitable source of care.

Choice Factors Compared to the Literature

Factors associated with health plan enrollments in the literature were examined for the Medicaid choosers in the PHRED demonstrations, with one notable exception, financial cost. Medicaid beneficiaries in the cash-grant categories cannot be charged for basic medical services, under current law, although they are subject to the same kinds of nonfinancial costs as others in society--most notably, time and inconvenience. Data collection from the demonstrations was structured to enable comparison of demographic and choice factors with published reports of other populations presented with a choice between traditional health insurance and an HMO option. Results for the PHRED choosers are presented below, by factor, with comments on their comparability to other groups.

Demographic Factors

Sex--Most of the subjects in the PHRED welfare office demonstrations were women, as would be expected in an AFDC-linked program; thus sex was not considered a determining factor. Comparison is not meaningful to the literature in which sex is variously reported not to be a predictor (Bice 1973, Berki et al., 1977) or to be related to choice with more males choosing prepaid systems (Moustafa et al. 1971).

Marital status--In the literature (Berki et al. 1977, Metzner and Brashur 1967, Moustafa et al. 1971, Scitovsky et al. 1978, Tessler and Mechanic 1975), marital status is uniformly cited as a significant factor in choice of prepaid systems, especially closed-panel prepaid systems. Again, the PHRED choosers, predominantly AFDC mothers, are by definition, single heads of households, with some married couples eligible by virtue of unemployment or disability. Comparison is not meaningful for this factor.

Education--While Tessler and Mechanic (1975), Berki et al. (1977), and Juba et al. (1980) did find significance in more education as a determinant of choice of a prepaid system, others (Moustafa et al. 1971, Metzner and Bashshur 1967, and Richardson et al. 1976) decided that it was not a differentiating factor in the groups they studied. In the PHRED welfare office demonstrations, education did not seem to be significant, although slightly higher percentages of those who had more years of school choose HMOs.

Age--Age, particularly age of children, is often reported to be associated with an HMO choice in which maternity care and routine care for younger children are available without cost barriers (Dutton 1979, Hudes et al. 1979, Juba, et al. 1980, Luft 1978, Perkoff et al. 1974, Tessler and Mechanic 1975, and Wersinger et al. 1976.) Richardson et al. (1976) reported somewhat younger enrollees in their study of low-income choosers but found a pattern of larger families choosing the traditional option, while Bice, in his study of Title XIX choosers (1973) noted that although families with children were more likely to enroll in the plan, older families enrolled in "slightly greater proportions than those with no children" (p. 41). The seemingly contradictory findings for low-income people have been explained by Berki and Ashcraft (1979) who suggest, "expected future need for medical care is of concern not for the costs such care would entail, nor because of the necessity to insure against financial loss by enrolling in an HMO, but for where and how those services are to be obtained."

Age of children for the PHRED choosers is not consistently available for analysis, but for the welfare office methods it is assumed that they were young, since 66 percent of the choosers were less than 30 years of age. The HMO choosers in the welfare office were not significantly different in age from the fee-for-service choosers. Neither was age a differentiating factor within the methods. Data are not available on the age of a representative sample of mail and current method choosers;

however, within the sample of mail respondents interviewed, 37 percent were 60 years or older while only 21 percent were less than 30 years of age, indicating the skewed response from older beneficiaries, with AFDC beneficiaries less likely to respond to the mailing.

Number of Children--As discussed above, number of children is closely linked with age in the literature as an indicator of choice. Berki et al. and Bice (1973) found families with children more likely to enroll than single individuals, while Metzner and Bashshur (1967) identified small differences in choice behavior related to the number of children in the chooser's family. In their study of choice between open- and closed-panel HMOs, Scitovsky et al. found that families of two to four members were more likely to choose the open panel, while single choosers picked the HMO more often. Moustafa et al. noted that size of family per se was not the determinant, but reported that those with children favored more comprehensive services. The choosers in the demonstrations had rather small families, with 55 percent only one child and 27 percent, two children. Contrary to the popular conception of large AFDC family groups, in the PHRED sample a total of 82 percent had two or less children; in the AFDC population statewide, 66 percent had two or less children, indicating a possible lack of representativeness. Number of children was not available for a representative group of mail and current method choosers, but it was not a determining factor among the welfare office methods studied.

Ethnicity--This factor is not widely reported in the literature: Metzner and Bashshur (1967) did report a likelihood of minorities to enroll in a prepaid plan, although this finding may have been compounded by a geographical distance factor. In the PHRED studies, blacks were overrepresented in the sample (46.83 percent, compared to 30 percent statewide); however, data are not available to break out the ethnicity of the urban areas in which most HMOs are located and the sample may be more representative of those who could join a Medicaid contracting health plan.

At any rate, differences also were apparent in the choices of blacks and whites for two of the welfare office methods with more blacks (54 percent) than whites (33 percent) choosing fee-for-service on the basis of the brochure-only method; and more whites (48 percent) than blacks (31 percent) in the choosers of HMOs after the film presentation. (Translation problems prevented collection of sufficient data on spanish-speaking choosers to allow analysis by method.)

Health Status Factors

Although it was not possible to assess health status clinically, the demonstrations did collect some self-reported indicators of utilization and health status: numbers of visits to the doctor in the past year, for chooser and family; numbers of hospitalizations in the previous year, for chooser and family; and immediate needs for care. Comparisons in the literature are available, although definitions of variables are usually only approximate.

Recent utilization--Generally, prior utilization of ambulatory health services has not been predictive of HMO enrollment in the other studies (Roghmann et al. 1975; Berki et al. 1977; Juba et al. 1978). Roghmann et al. did find higher use rates among families for ambulatory care and for hospitalization, similar to the differing patterns for HMO choosers and families in the welfare office data. Bice's study (1973) of low income population choice-making, which included both those with Medicaid coverage and those non-eligibles who were financially vulnerable for costs unless they selected the HMO, found no relationship between health risk and choice for Medicaid eligibles, although there was a relationship for those who were not eligible. Cost seemed to be the factor related to utilization, with Medicaid eligibles making their choices on the relative attractiveness on service attributes. In the PHRED welfare office data, utilization may be more important as an indicator of a provider relationship than of health risk. This hypothesis is supported

by results from a study in which non-Medicaid former members of an independent practice association enrolled in a Blue Cross-Blue Shield, system despite its more limited benefits, in order to maintain a provider relationship they valued (Ashcraft et al. 1978). In the Richardson et al. (1976) study of model city choosers between a prepaid group practice and an open-panel plan, the group practice (which may be taken to correspond to the HMO choices in the PHRED demonstrations) was selected by those with somewhat fewer ambulatory visits and hospitalizations.

Existing Provider Relationship--In their review of dual-choice factors, Berki and Ashcraft (1980) provide a summation of the findings in the literature:

> There is ample evidence, however, that a pre-enrollment relationship with a provider deters selection of a staff model HMO (Gaus, 1971; Roghman et al., 1975; Berki et al., 1977a; 1978; Jurgovan and Carpenter, 1974; Anderson and Sheatsley, 1959), except when that provider becomes part of the HMO's staff (Jurgovan and Carpenter, 1974). Moreover, when that relationship is a satisfactory one, as judged by satisfaction with various dimensions of the relationship, the likelihood of terminating it by enrollment in an HMO is decreased (Juba et al., 1978; Tessler and Mechanic, 1975). And conversely, it has consistently been found that the absence of a relationship with a provider increases the likelihood of selection of a plan that offers the opportunity for one to be established (Tessler and Mechanic, 1975; Berki et al., 1977a; 1978; Richardson et al., 1976; Juba et al., 1978). Prior use of clinics (Anderson and Sheatsley, 1959), neighborhood health centers, outpatient departments and emergency rooms where the opportunity to develop a continuing relationship with a single physician is less likely, were found among those who selected enrollment in a group practice HMO (Roghmann et al., 1975; Berki et al., 1977a; Ashcraft, 1978).

These findings have all been confirmed in the welfare office data, suggesting that Medicaid choosers are as affected by the provider relationship factor as are other groups. The satisfaction variables cited by Bice (1973) and Richardson (1976) seem especially important for the Medicaid and low-income choosers since the cost and financial vulnerability factors which might countervail are absent.

Previous Knowledge of the HMO Option

Several previous studies have examined the level of awareness of the HMO alternative in the choosing population and its impact on choice. Bice (1973) found those who were aware of the plan in advance of the choice to be more likely to enroll, while Metzner and Bashshur (1967) cited awareness as an important factor (related to income level) in the union group they studied. Moustafa et al. (1971) found UCLA employees to be generally aware of the main differences between the two alternative delivery systems offered, although details of coverage were not well known, even after choice. In the latter respect, the PHRED enrollees seemed to have benefitted from the choice counseling and emphasis on presentations of information in the demonstrations, as they generally scored well on the details of enrollment in comprehension tests. Those with previous knowledge of or experience with the HMO enrolled in higher percentages, as in the other studies, suggesting another basic characteristic not affected by Medicaid status.

Expectations About Care

The PHRED welfare office HMO enrollees were more likely to perceive the health care that they would get in a health plan as "better" than the Medicaid and non-Medicaid low income choosers in the East Baltimore study reported by Bice (1973). (PHRED choosers: "better," 66 percent; "the same," 31 percent. Bice study: "better," 24 percent, "the same" 48 percent.)

Reasons Offered for Choices

Beyond demographics and health status-related information, a number of investigators have attempted to explain choice with data that are subjective. Beginning with Gaus (1971), they have asked respondents to give reasons for joining or not joining a health plan. Both open- and

closed-ended questions have been asked either to identify the "main reason," as in the PHRED interviews, or to rank a number of hypothesized motivations in order of their importance. The differing methodologies make direct comparison difficult, but the factors identified most consistently as influencing the decision are those found in the PHRED welfare office demonstration data as well, absent the cost consideration. The Gaus study (1971) asked local residents for the major reason for joining or not joining the Columbia HMO. Among those who had enrolled, the large range of available services (44 percent), the health plan's association with a prestigious medical school (24 percent), and the convenience of the clinic (11 percent) were the most commonly offered reasons. Those who had not enrolled most often attributed their decisions to the higher cost of the health plan (42 percent), to satisfaction with their current arrangements (22 percent), or to the limited selection of physician in the plan (12 percent). Tessler and Mechanic (1975) found those selecting the prepaid option cited comprehensive coverage (30 percent) and the lack of an existing physician relationship (23 percent).

Knowledge of the existence of the prepaid plan or previous experience with it were also important factors (13 percent). Roghmann et al. (1975), examining a choice which included three HMO options (open- and closed-panel) and a regular Blue Cross plan, found, after "financial considerations," that "comprehensive coverage" (21 percent of all enrollees) was the most commonly given reason for the prepaid choice. With the Seattle low-income choosers, Richardson et al. asked an open-ended question similar to the PHRED demonstration's. Although the open-panel option, an independent practice association, was actually a prepaid alternative, its large number of providers, delivery characteristics, and the absence of cost to the chooser make it similar to the fee-for-service system offered to Medi-Cal eligibles. Convenience (24 percent), previous enrollment or current relationship with a doctor in the health plan (23 and 14 percent, respectively), and the recommendation of friends (18 percent), were the most commonly given responses of those who chose the closed-panel HMO. Having a doctor in the system

(32 percent), "had it before" (14 percent), and a rather ambiguous reason, "reading pamphlets" (17 percent), were the most frequently offered reasons for the choice of the more traditional coverage.

PHRED's marketing and enrollment demonstrations developed several methods which could be used in this state and others to offer a choice of health care delivery systems to Medicaid beneficiaries. The methods demonstrated produced varyng choice rates for HMOs; local conditions at the sites seemed more influential than the method in most instances.

The demonstrations' overall choice rate, 17 percent for HMOs, and the cost, which was lower than the cost per enrollment for door-to-door solicitation, convinced policy makers in California to end door-to-door solicitation and place special dual choice workers in each welfare office in which an HMO choice is available.

Comparison of applicable characteristics of the choosers and the reasons for choice, given explicitly or assumed on the basis of other information, with similar studies reported in the literature indicates that Medicaid people are similar to other groups of choosers. Especially of interest are the existance of a provider relationship and satisfaction of the patient with the provider: the demonstration subjects were similar in many respects to those studied in other settings. Those most likely to enroll did not have a current provider relationship or were less satisfied with it. They tended to be newer to the system and to report lower rates of utilization of health care services, although they said they needed care at a higher rate than those who chose the fee-for-service system.

Major findings of the project included:

- Personal presentations made by State workers and HMO representatives were more effective than film or printed presentations in producing HMO enrollments, but also more expensive.

- Personal presentations made by eligibility workers were not as effective as the other methods, although they were slightly more productive of enrollments than the printed presentations.

- Problems with adding tasks to the welfare office workload, and difficulty in monitoring and training all the workers in an office, make it cost-effective and more productive to schedule a specially-trained worker with the dual choice responsibility.

- Marketing HMOs and other alternative systems by direct mail to eligible beneficiaries does not produce a viable enrollment or program growth, although it may serve indirectly to reinforce information given in the welfare office.

- The solicitation methods used by the majority of those California HMOs which market to Medi-Cal beneficiaries are expensive and inefficient in locating eligible beneficiaries, but they do produce enrollments in proportion to the amount of resources invested.

- Comprehension testing indicated that the enrollees who heard or received objective information about the dual choice, in the welfare office or in the mail, were better informed about the meaning of joining a health plan than those enrolled through door-to- door solicitation by a health plan marketing representative.

- When information is offered in the AFDC eligibility process, HMOs can be relieved of the marketing responsibility; however, beneficiaries enroll in different proportions in competing health plans. Over time, the shift to dual choice in California will increase the total program enrollment, but some plans will grow disproportionately while others may decline.

Recommendations for Future Research

The huge body of data from the PHRED demonstrations was subjected only to very basic forms of analysis. The setting of the research, within a politically dynamic public program, gave high priority to making changes on the basis of the practical information from the demonstrations. The data do exist, however, and at some time they may be used by the Department of Health Services to fill in the rather sketchy outlines of the profiles. Copies of the files are available to other researchers as well.

Further study of the choosers in the PHRED demonstrations might concentrate on examining their satisfaction in their chosen options, either directly through a survey or by examining State data files for disenrollment into the fee-for-service system and switches to other health plans by the HMO choosers and subsequent enrollment by the fee-for-service choosers into HMOs. The other aspect of longevity, continued eligibility for Medi-Cal, should also be examined, again through State history files, in order to answer another of the questions the demonstrations left unanswered: the degree of difference in eligibility stability, if any, of those who select the HMO and fee-for-service systems.

Finally, differences in service utilization between the two groups, subsequent to choice, would fill in the last gap in knowledge of the characteristics of Medicaid choosers. The Department of Health Services is undertaking a study of guaranteeing eligibility to HMO choosers which will collect this information to compare it to the utilization experience of those who choose the fee-for-service system. The administrative costs of repeated eligibility determinations will also be considered.

Recommendations for Public Policy

Another major report of the marketing demonstrations is a "how-to-do-it" manual for state agencies considering implementation of a dual-choice method for HMO enrollment.* Suggestions are made at length in that volume about the optimum approaches for public sector marketing and the legal, practical, and political factors which should be considered. Here, we will give only three pieces of advice to policy-makers, based on the experience of the demonstrations:

1. Dual-choice methods work--especially the use of "dedicated," knowledgeable special Medicaid workers in the welfare office. They can and should replace solicitation and other eclectic marketing approaches.

2. The best possible methods cannot counter the deleterious effect of eligibility fluctuations, which create administrative problems for all concerned--the HMO, the eligibility determiners in the county or state offices, and, of course, the beneficiaries, whose need for health care may or may not coincide with the processing of papers. Expansion of the cost-effective prepaid program, to a great degree, depends on a broader view of poor people's eligibliity for health care than is allowed by month-to-month ties to the public assistance process.**

3. Even with full implementation of the model method for dual-choice, and with some fixed period of eligibility, as long as the choice is voluntary, enrollment of the Medicaid population in HMOs will

*Marketing HMOs to Medicaid: A Manual for State Agencies, 1981.

**At this writing, there are promising developments: waivers of Federal requirements to allow a fixed eligibility period in HMOs are possible.

not approach universality. Policy-makers must develop realistic expectations for program enrollment; the PHRED demonstrations indicate the penetration rate of HMOs into the general population is a good benchmark.

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APPENDIX A

Medicaid HMO Marketing Practices in Other States

In August 1979, a preliminary survey of other states was conducted by telephone to determine whether there was evidence of a trend toward more interest in Health Maintenance Organizations (HMOs), and especially if there were more interest among the Medicaid directors in establishing contracts with HMOs to provide prepaid health care to Medicaid beneficiaries. The survey concentrated on marketing laws and allowed practices.

A relative lack of understanding of the concept of HMOs was apparent. Some staff members of the Medicaid Medical Assistance Units in nearly every region were completely unaware of the existence of such organizations in their state. After providing a brief description of an HMO, there was sometimes an indication of knowledge of the existence of one or more in the state, but there was more often an indication that the state had not undertaken to establish contracts with them.

This lack of understanding and general unfamiliarity with the concept had noticeably changed when the survey was repeated one year later. Some of the states which formerly had had no operating HMOs (even if for "private patients" only), have since had some experience with attempts (not all successful) to establish HMOs. A few states had even begun to negotiate capitation rates in preparation for a contract. In no state was there evidence of restrictive legislation which would hinder the development of HMOs, either for employee groups or for Medicaid recipients.

The August 1980 survey showed that there were 15 states and the District of Columbia with HMO contracts and four others which had begun the process to establish them. Some of the states were moving more rapidly than others and projected completion of negotiations within a few months. Other states were planning on more distant completion dates: two in 1981, and one in fiscal year 1982-83.

Several combinations of marketing methods were being proposed, tried, adapted, and accepted or rejected. Perhaps because of the unsavory history of door-to-door marketing of health plans, most of the states with HMO contracts do not permit this form of marketing: seven forbid it and four others do not use it, while five allow it. (However, of the five states which allow it, only one takes the precaution of licensing the enrollers.)

Eleven of the states have adopted a program of state-controlled mailings of HMO information to all eligible persons (usually by means of computer-generated lists by ZIP code). There were mixed feelings about the success of this method. The issue of confidentiality, and the restrictions on the use of names and addresses by HMO representatives appeared to be better understood than in the previous year but it

remained a problem. A few states have allowed the release (by the counties' social services offices) of the names of newly eligible persons. In most of the states (12), a program to educate the new Medicaid beneficiaries about the "dual choice" method of delivery of health care has been undertaken by state and/or county workers in the social services offices as part of the eligibility process. There have been varying degrees of success with this method.

From the second survey, a general increase in the awareness of HMO activity, of understanding the benefits of establishing contracts with HMOs, and of the need for caution in doing so, was apparent among the staff at the Medicaid agencies. More states were establishing contracts and more were planning to do so. There were a few states where no HMO activity was reported; they were mostly rural. The more populous, heavily urban states appear to have much more HMO activity. The idea of the state serving as a liaison between the Medicaid recipient and the HMO appeared to be gaining acceptance across the country.

Medicaid Marketing Practices by States
1980

State	Number of Contracts With HMOs	Total 1979 Enrollment[a]	Door-to-Door Solicitation Allowed?	Are Mailings Done?	Welfare Office Choice
California	12	97,750[b]	Yes, on waiver basis only	Yes	enrolled
Colorado	2	1,002[b]	Yes, but not practiced	Yes	referred
District of Columbia	1	735	Yes, but not practiced	No	referred
Florida	10/80 planned				
Georgia	planned		No	?	referred
Hawaii	1	2,806	not practiced, not prohibited	No, use to	rep in office
Illinois	1	2,196	No	Yes	No
Maryland	7	3,175[b]	Yes	Yes	No
Massachusetts	4	3,425[b]	Yes	Yes	referred & enrolled
Michigan	5	63,854	No	Yes	referred
Minnesota	4	301	not practiced, not prohibited	Yes	referred & enrolled
New Hampshire	FY 82-83 planned				
New Jersey	1/81 planned		No	Yes	rep in office
New York	4	44,252[b]	No	Yes	referred & enrolled
North Carolina	1981 planned				
Ohio	1, plus 1 in 10/80	3,505	not practiced, not prohibited	Yes	referred
Oregon	1	11,554[c]	No	Yes	referred
Pennsylvania	1[d]	1,056	No	Yes	rep in office
Rhode Island	1	135	Yes	No	referred
Utah	1	4,470	Yes[e]	No	referred, rep-office
Washington	3	5,251[b]	No	Yes	referred rep-office
Wisconsin	2, plus 1 planned	778	No	No	referred & enrolled
Total		246,268			

a Membership as of 6/30/79.
b 1979 membership in fewer plans than contracted with in 1980.
c 1979 membership in one plan more than contracted with in 1980.
d At-risk contract, not a PHP.
e Names of eligibles (but no addresses) are provided to the plan.

Selected Data

48 states contacted 1980 (California, Guam, West Virginia not contacted)
4 more states to establish contracts with one - two years
15 states have contracts with the State to provide health care to Medicaid beneficiaries

MARKETING (of those responding)*

	Allowed	Not Allowed
Door-to-door marketing	5	11
	Yes	No
State licenses/examines/regulates enrollers	1	10
Mailing method	10	4
State controlled	9	1
Dual choice in Social Services Office	12	3
Enrollment at intake	5	6
HMO representative in office	2	
Refer to HMO for enrollment	11	
Plans' access to names of eligible persons		8
Follow-up only	2	
County gives names (only) of newly eligible persons	3	

DISENROLLMENT

State handles	0	
County handles	3	5
Plan handles	7	1
Automatic on request	6	2
Requires state approval	1	5

*Not all respondents answered all questions; some states were still formulating policy.

What other states are doing about Medicaid marketing

(Data from PHRED survey (telephone) of all state and territorial Medicaid agencies, August 1980.)

Fifteen states and the District of Columbia currently report contracts with HMOs for Medicaid.

Of these, nine allow door-to-door solicitation; however, in four states and the District of Columbia, it is not currently used. The other seven states specifically prohibit solicitation, although some have allowed it in the past. Five additional states do not have current contracts, but are developing them at the present time. At least three have decided to prohibit door-to-door solicitation.

Many states assist plans by sending marketing mailings (12); dual choice is offered in the welfare offices in 15 states, with four states reporting an HMO representative in at least some of the offices and the others split between workers enrolling directly and referring to plans for follow-up. In one state, names of eligibles (but not addresses!) are given to the HMO for leads.

A variety of mixtures of these methods are reported by the states, but no additional methods are reported.

Six states use more than one method within the state.

APPENDIX B

Informational Materials Used in Demonstrations

(Examples only; full set available from NTIS)

What's the difference

BETWEEN A MEDI-CAL CARD AND A MEDI-CAL HEALTH MAINTENANCE ORGANIZATION (HMO-PHP)?

¿Cuál es la diferencia

ENTRE UNA TARJETA DE MEDI-CAL Y UN PLAN DE MEDI-CAL (PHP-HMO)?

Please read this information carefully.

You will make your Medi-Cal choice when you come for your interview.

Medi-Cal is the State's program for people who need help in paying for health care. If you get a county AFDC check or a gold Social Security check, you have a choice to make about your health benefits. You can choose either the monthly Medi-Cal sticker card program, where you locate your own doctor whenever you need one, or a Medi-Cal prepaid plan, where you get all your services from a single health plan each time you need care. These health plans are now called health maintenance organizations, or HMOs, and they have to meet requirements of both the Federal and State governments.

Although HMOs often provide extra services, either form of Medi-Cal can give you the health care that you and your family need.

Dos Clases de Medi-Cal

Medi-Cal es un programa del Estado para personas que necesitan ayuda económica para pagar servicios médicos para el cuidado de la salud. Si recibe un cheque del condado AFDC (Ayuda para Familias con Niños Dependientes) o un cheque dorado del Seguro Social, usted puede decidir acerca de sus beneficios médicos para el cuidado de su salud.

Usted puede escoger, ya sea el programa regular de Medi-Cal, recibiendo mensualmente una tarjeta de identificación que puede usar con el médico privado que usted escoja cuando lo necisite, o un plan prepagado de Medi-Cal, en donde recibe todos los servicios médicos necesarios dentro de un sólo plan de salud, cada vez que necesite de estos servicios. Estos planes de salud se llaman ahora Organizaciones para el Mantenimiento de la Salud o Health Maintenance Organizations (HMOs), y tienen que satisfacer los requerimientos de los gobiernos Federal y del Estado.

Aún cuando HMOs frecuentemente proveén servicios extra, cualquiera de estos dos programas de Medi-Cal, puede darle los servicios para el cuidado de la salud que usted y su familia necesiten.

Advantages and Disadvantages

There are advantages and disadvantages to both kinds of Medi-Cal. You will want to consider them carefully before you decide which kind is best for you and your family.

Included with this brochure is specific information about the HMOs that you may join in your area, including a list of the extra services they provide. As you read the information about the HMOs, here are some things to consider before you decide which kind of Medi-Cal you want:

1. • When you become a member of an HMO, you have to use the HMO's doctors and other services (except if you can't get there in an emergency). • If you have monthly Medi-Cal stickers, you can use any doctor you choose — as long as he or she will take Medi-Cal patients.
2. • When you become a member of an HMO, you sign a contract (enroll) and you have a guaranteed right to medical care. • When you have Medi-Cal stickers, services can be guaranteed available *only* at your county hospital or other county facilities.
3. • In an HMO, there is a grievance system that is set up to try to solve any problems members have with their health plan's services. • If you have a problem with a doctor or other provider under the regular Medi-Cal system, it's up to you to discuss and settle it with the doctor or provider — or to find another to take care of you.
4. • When you become a member of an HMO, you remain a member as long as you continue to receive your AFDC or gold check. If, for some reason, you become unhappy with the HMO, it is possible for you to disenroll. Getting out of the health plan usually takes approximately 60 days.

Ventajas y Desventajas

Los dos programas de Medi-Cal, con etiquetas y prepagado, tienen sus ventajas y desventajas. Usted debe de considerarlos cuidadosamente antes de decidir cuál es el mejor programa para usted y su familia.

Incluida con este folleto es la información específica acerca de los HMOs en su área, con una lista de los servicios extra que proveén a los beneficiarios de Medi-Cal. Cuando lea la información acerca de HMOs, éstas son algunas cosas que debe de considerar antes de decidir qué forma de Medi-Cal desea escoger:

1. • Cuando se subscribe a un HMO tiene que hacer uso de sus médicos y demás servicios (excepto en caso de emergencia cuando la facilidad no sea accesible a Ud.) • Si tiene Medi-Cal con etiquetas puede usar el médico de su preferencia, siempre y cuando el o ella acepte pacientes con Medi-Cal.
2. • Cuando se subscribe a un HMO, es como si firmara un contrato que le garantiza sus derechos a recibir cuidados para la salud. • Cuando tiene Medi-Cal con etiquetas, servicios médicos pueden ser garantizados a su disposición *solamente* en el hospital y otras facilidades de su condado.
3. • En un HMO hay un sistema de quejas que sirve para resolver cualquier problema que un subscriptor pueda tener con los servicios del plan de salud al que pertenece. • Si tiene un problema con el médico u otro proveedor bajo el sistema de Medi-Cal con etiquetas, depende de usted el discutirlo y resolverlo con el médico o proveedor, o encontrar a otro que se haga cargo de usted.
4. • Cuando se subscribe a un HMO, usted sigue siendo miembro por tanto tiempo como continúe recibiendo su cheque AFDC o un cheque dorado. Sin embargo, si por alguna razón usted ya no esta satisfecho con HMO, puede desenrolarse y dejar el plan de salud, un proceso que se lleva aproximadamente 60 días. • Con Medi-Cal con etiquetas, si

• With a Medi-Cal sticker card, if you become dissatisfied with your doctor, you can leave him or her and try to find another who will accept Medi-Cal patients.

5. • When you join an HMO, the HMO will send you a booklet that will tell you where its doctors, pharmacies, and other services are located, what their normal hours are, how to make an appointment for the kind of service you need, and what to do in an emergency. This information can be especially important to you. • There is no similar information package available for regular Medi-Cal, but it is important for you to ask your doctor in advance what to do if your child suddenly runs a fever in the middle of the night.

How to Choose

As long as you continue to receive your AFDC or gold check, you will not have to pay anything for your Medi-Cal benefits — either way. But you should still choose carefully.

For example, if you already have a family doctor who knows you and any health problems you may have, you are probably wise to stay with that doctor if he or she accepts Medi-Cal patients. But, if you do not have a family doctor, or if you can't find a doctor who will accept Medi-Cal patients, you may be better off joining an HMO — so that you will not have to try to find a doctor when you or your child become sick.

In making your choice, be sure to consider your whole family. For example, the State requires each HMO to give children who are plan members a full health examination to detect problems *before* they become serious. (This program is called Child Health Disability Prevention — CHDP.) You can get these exams for your children with a regular Medi-Cal card, but you must find a doctor who is willing to provide the service.

usted no está satisfecho con su médico puede dejarlo y encontrar otro quien acepte pacientes de Medi-Cal regular.

5. • Cuando usted se enrola a HMO, esta organización le enviará un libreto que le informará de sus médicos, farmacias y demás servicios; también le informará a dónde están localizados, cuáles son las horas normales de servicio, cómo hacer una cita y que debe de hacer en un caso de emergencia. Esta información es de mucha importancia para usted. • No hay información similar de Medi-Cal con etiquetas, pero es importante que usted pregunta a su médico antes de que debe de hacer si su niño se le enfermera de repente a la media noche.

Como Escoger

Por el tiempo en que continue recibiendo su cheque de AFDC o un cheque dorado, usted no tendrá que pagar nada por los beneficios de Medi-Cal en cualquiera de sus dos formas. Pero aún así, debe de escoger con mucho cuidado.

Por ejemplo, si usted tiene un médico para toda la familia a quien ven con regularidad y sabe qué problemas de salud tienen, sería más prudente quedarse con el mismo médico, si es que acepta pacientes con las etiquetas de Medi-Cal. Pero si no lo tiene o no puede encontrar un médico que acepta pacientes con etiquetas de Medi-Cal, sería mejor subscribirse a un HMO y evitar el problema de encontrar a última hora un médico que lo atienda cuando usted o su niño se enferman de repente.

Cuando escoja, asegúrese que toma en consideración la familia entera. Por ejemplo, el Estado requiere de cada HMO que de a los niños (hasta la edad de 21 años) miembros del plan, un completo exámen de salud de acuerdo con el programa de Prevención contra la Incapacidad en la Salud del Niño (Child Health Disability Prevention), para descubrir problemas de salud *antes* de que se conviertan en problemas serios. (Usted puede pedir estos servicios de un proveedor de Medi-Cal regular. El Estado no puede requerir de los médicos privados que lleven a cabo estos exámenes, pero sí pagará por ellos.)

What you Can Get From Medi-Cal

These are the basic services that both forms of Medi-Cal provide for you:

- Visits to doctor's offices.
- Hospital and nursing home care when ordered by your doctor.
- Special checkups for children under age 21 and treatment if needed.
- Laboratory and X-ray services.
- Mental health services.
- Dental care.
- Chiropractic services.
- Medications.
- Eyeglasses, hearing aids, medical supplies, and medical equipment when ordered by your doctor.

Lo Que Puede Obtener de Medi-Cal

Estos son los servicios básicos que Medi-Cal, en sus dos formas, provée para usted:

- Visitas a la oficina del médico.
- Hospital y casa de convalecencia para enfermos cuando el médico lo ordene.
- Exámenes para niños hasta la edad de 21 años y tratamiento si es necesario.
- Servicios de laboratorio y rayos X.
- Servicios para la salud mental.
- Servicios dentales.
- Servicios quiroprácticos.
- Medicinas.
- Lentes ó anteojos, aparatos para oir, suplementos y equipo médico cuando el medico lo ordene.

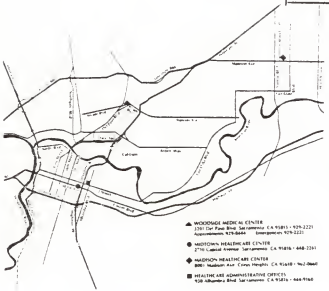
(DHS 5/79)

Usted tendrá que hacer su elección de Medi-Cal cuando venga a su entrevista.

Por favor lea esta información cuidadosamente.

California State Department of Health Services
455 Capitol Mall, Suite 250
Sacramento, Calif. 95814

Appendix B
HMO Brochure - Health Care



Healthcare Service Area Map

Area de Servicio de "Healthcare"

California State Department of Health Services
455 Capitol Mall, Suite 250
Sacramento, Calif. 95814

For further information, call
Healthcare 444-9160

GROUP HEALTH SERVICE PLAN

HEALTHCARE

444-9160

Group Health Service Plan is a nonprofit, prepaid group practice medical and hospital care plan for persons living in Sacramento, Yolo, Placer, and El Dorado counties within a 20-mile radius of any of the three Healthcare health care centers.

Healthcare is a direct-care health service system, providing continuing care for the entire family, as well as treatment for major illness and accidents, in its health centers, in the hospital and, on occasion, in the home. Healthcare encourages the use of its preventive, diagnostic, therapeutic, and rehabilitative services for health maintenance, early disease detection, and prompt medical treatment.

Grupo Del Plan de Servicios Para la Salud "Healthcare"

El Grupo del Plan de Servicios para la Salud ("Healthcare") no es lucrativo. Es un plan de salud prepagado de servicios médicos y de hospital para las personas residentes en los condados de Sacramento, Yolo, Placer y El Dorado, dentro de veinte millas a la redonda de cualquiera de los tres centros "Healthcare."

"Healthcare" es un sistema de servicios para la salud que provee cuidados directos y continuos para la familia entera, así como tratamiento de enfermedades graves y accidentes, en sus centros de salud, en el hospital y ocasionalmente en su hogar. El plan anima el uso de sus servicios preventivos, diagnósticos, terapéuticos y de rehabilitación, para el mantenimiento de la salud, temprana detección de enfermedades, y su tratamiento médico.

Services Available	Service Location Localidades de Servicios	Servicios Disponibles
Primary care, obstetrics and gynecology, pharmacy, physical therapy, laboratory and X-ray services. Specialist care, vision care, mental health services and home health services on referral. Special programs: Weight and smoking control, family planning and diet counseling.	Woodside Medical Center 3201 Del Paso Boulevard Sacramento, CA 95815 (916) 929-2221 Service Hours: 9:00 a.m.-5:00 p.m. (Mon.-Fri.) 9:00 a.m.-4:30 p.m. (Saturday) Horas de Servicio: 9:00 a.m.-5:00 p.m. (lunes a viernes) 9:00 a.m.-4:30 p.m. (sabados)	Cuidados primarios, obstetricia/ ginecologia, farmacia, terapia fisica, laboratorio, y servicios de rayos X.-Especialistas: cuidado de los ojos, salud mental y servicios para la salud en su hogar, si el médico lo refiere. Programas especiales: control de peso y para no fumar, planeamiento de familia, consejeros para la dieta.
Primary care and pharmacy. Specialist care, vision care, mental health services and home health services on referral. Other services available at Woodside Medical Center. Special Programs: Weight and smoking control, family planning and diet counseling.	Midtown Healthcare Center 2710 Capitol Avenue Sacramento, CA 95816 (916) 448-2261 Service Hours: 8:00 a.m.-4:30 p.m. (M-T-W & F) 9:00 a.m.-4:30 p.m. (Thursday) Horas de Servicio: 8:00 a.m.-4:30 p.m. (lunes a miercoles y viernes) 9:00 a.m.-4:30 p.m. (jueves)	Cuidados primarios y farmacia. Especialistas, cuidado de los ojos, salud mental y servicios para la salud en su hogar, si el médico lo refiere. Otros servicios disponibles en el Centro Médico Woodside. Programas especiales: control de peso y para no fumar, planeamiento de familia, consejeros para la dieta.
Primary care, pharmacy, laboratory and X-ray services. Specialist care, vision care, mental health services and home health services on referral. Other services available at Woodside Medical Center. Special Programs: Weight and smoking control, family planning and diet counseling.	Madison Healthcare Center 8001 Madison Avenue Citrus Heights, CA 95610 (916) 962-0660 Service Hours: 9:00 a.m.-5:00 p.m. (Mon.-Fri.) Horas de Servicio: 9.00 a.m.-5:00 p.m. (lunes a viernes)	Cuidados primarios, farmacia, laboratorio, y servicios de rayos X. Especialistas, cuidado de los ojos, salud mental y servicios para la salud en su hogar, si el médico lo refiere. Otros servicios disponibles en el Centro Médico Woodside. Programas especiales: control de peso y para no fumar, planeamiento de familia, consejeros para la dieta.
Major or minor surgery, coronary and intensive care, maternal and newborn care, 24-hour emergency service.	Hospitals in the Sacramento area, as designated by the attending Healthcare physician. Hospitales en la area de Sacramento, son designados por el medico que lo atiende.	Cirugía mayor y menor, cuidados maternos (servicios de maternidad) y para el recien nacido, servicios de emergencia 24 horas al día.

24-Hour Emergency Care

(916) 929-2221

For more information, call Healthcare at 444-9160 or the Department of Health Services at 1-800-952-5528 (no charge to you).

Servicio de Emergencia 24-Horas al Dia

(916) 929-2221

Para más información, favor de llamar al plan de salud al teléfono número 444-9160 o al Departamento de Servicios de Salud al numero 1-800-952-5528 (llamada gratuita)

California Medical Grou Health Plan, Inc. (CMGHP)

CMGHP, Inc. is a Federally-qualified Heal Maintenance Organization (HMO) curren providing medical care for 114,000 membe in Southern California. Of these membe 59,000 are covered through private a governmental employer group health bene programs and 55,000 are Medi-Cal recipien covered through a contract with the Sta Department of Health Services which h been in effect for more than six yea CMGHP, INC. currently has the largest Me Cal HMO membership in California.

Grupo Médico Californ Plan de Salud, Inc.

El Grupo Médico California Plan de Sal Inc., es una Organización para el Mante miento de la Salud cualificada Federalme (HMO). En la actualidad, proveé cuidac médicos para 114,000 miembros de grur privados u del gobierno y 55,000 más quier son recipientes de Medi-Cal, están cubier por medio de un Plan de Salud contrat por el Departamento de Salud del Estado

El Grupo Médico California Plan de Sal Inc., ha hecho un contrato con el Dep tamento de Salud del Estado por los últim seis años y actualmente tiene la más gran cantidad de miembros de Medi-C prepagado en California.

California Medical Group Health Plan, Inc. HEALTH CARE CENTERS

Anaheim/Fullerton Area (M)
1401 Brookhurst Road
Fullerton, CA 92633
(Opening on or about November 1979)

Costa Mesa Medical Group (M)
1755 Orange Ave., Suite A
Costa Mesa, CA 92627

East Long Beach Medical Group (MEVP)
2220 Clark Ave.
Long Beach, CA 90815

El Monte Medical Group (MEDVP)
10454 E. Valley Blvd.
El Monte, CA 91731

Fair Oaks Medical Group (MEDVP)
401 S. Fair Oaks Ave.
Pasadena, CA 91105

Long Beach Regional Dental Care Center
3210 Long Beach Blvd.
Long Beach, CA 90807

North Sepulveda Medical Group (MD)
909 N. Sepulveda Blvd.
El Segundo, CA 90245

North Valley Medical Group (MDVP)
10875 San Fernando Rd.
Pacoima, CA 91331

Olympic Medical Group (MP)
11275 W. Olympic Blvd.
Los Angeles, CA 90064

Orange-Chapman Medical Group (MVP)
1937 W. Chapman Ave.
Orange, CA 92668

Pico Rivera-Downey Medical Group (M)
9155 Telegraph Rd.
Pico Rivera, CA 90660
(Opening on or about April 1979)

Pomona Medical Group (MEDVP)
887 E. Second St.
Pomona, CA 91766

15. Santa Ana Medical Group (MEDP)
    2435 N. Grand Ave.
    Santa Ana, CA 92701
16. Tarzana Medical Group (M)
    5536 Reseda Blvd.
    Tarzana, CA 91356
17. Vermont-Jefferson Medical Group (MEDVP)
    3031 S. Vermont Ave.
    Los Angeles, CA 90007
18. West 57th Street Medical Group (MP)
    805 W. 57th St.
    Los Angeles, CA 90037
19. West San Fernando Valley Area (M)
    7111 Winetka
    Canoga Park, CA 91306
    (Opening on or about June 1979)
20. Wilmington Medical Group (M)
    1250 N. Avalon Blvd.
    Wilmington, CA 90744

M — Medical
Médicos
E — Open 24 hours, 7 days a week
Servicios 24 horas al día
D — Dental
Dentales
V — Vision Care
Cuidado de la visión
P — Pharmacy
Farmacia

Service Locations Available
Fifteen health care centers in Los Angeles, Orange, and San Bernardino Counties. (See map for services available at each center.)

Locales de Servicio Disponibles Para Enrolamiento
El los condados de Los Angeles, Orange y San Bernardino, 15 centros para el cuidado de la salud. (Vea la lista para servicios disponibles.)

California State Department of Health Services
455 Capitol Mall, Suite 250
Sacramento, Calif. 95814

Services Available
Twenty-four hour physician services, X-ray, laboratory, pharmacy, dental, optometry (including eyeglasses), emergency transportation and Child Health and Disability Prevention physicals.

Extra Services

Diabetes, hypertension, weight control, smoking control, family planning, and health education.

Physicians Available
General practitioners, family practitioners, pediatricians, obstetricians-gynecologists, and all other specialists as required.

Hospitals Used
Local community hospitals (selected by the plan and plan physicians).

For more information, call the health plan (collect, station to station) at (213) 553-5494 or the Department of Health Services at 1-800-952-5528 (no charge to you).

Servicios Disponibles
Servicios médicos 24 horas al día, rayos X, laboratorio, farmacia, dental, optometría (incluyendo anteojos), transportación de emergencia, y exámenes físicos bajo el Programa Prevencion contra la Desabilidad en la Salud del Niño.

Servicios Extra

Diabetis, hipertensión, control de peso y para no fumar, planeamiento de familia, y educación de salud.

Médicos Disponibles
Médicos en medicina en general, médicos para la familia, obstetricia/ginecología y todas las demás especialidades requeridas.

Hospitales en Uso
Hospitales de la comunidad. (Elegidos por el Plan y sus médicos.)

Para más información, llame al Plan de Salud (llamada por cobrar o de estación a estación) al número 553-5494 o al Departamento de Servicios de Salud a número 1-800-952-5528 (llamada gratuita).

(DHS 5/79)

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
SACRAMENTO, CA 95814

Appendix B

Mailed Cover Letter
(English Version)

(Véase el otro lado para la versión en español)

Dear Medi-Cal Beneficiary:

You can make a choice about your health care. You may continue to receive your benefits with your stickers--from the county hospital or from any private doctor or other provider who will accept your Medi-Cal card. Or you may join a Health Maintenance Organization (HMO) which contracts with the State of California to provide all medically necessary care to eligible Medi-Cal recipients who choose to enroll. You have no costs for Medi-Cal health care under either system.

The information enclosed with this letter will help you select the type of health care which best suits your personal needs and those of your family. Please read it carefully and let us know your choice by filling out the enclosed card and sending it back to us. You will remain eligible for Medi-Cal services whatever you decide, as long as you are eligible for aid.

We want to be sure that you have all the information you need to make your choice. If you have any questions about the information or this letter, you may call the Department of Health Services on our toll-free line (no charge to you), 1-800-952-5528. I encourage you to think it over carefully and make the decision that will provide the best health care services for you and your family.

Sincerely,

Elisabeth H. Lyman

Elisabeth Lyman
Deputy Director
Medical Care Standards Division
Department of Health Services

Enclosures

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
SACRAMENTO, CA 95814

(See other side for English version)

Appendix B
Mailed Cover Letter
(Spanish Version)

Estimado beneficiario de Medi-Cal:

Usted puede escoger la clase de servicios médicos que más le convenga para usted y su familia. Puede continuar recibiendo sus beneficios con sus etiquetas, de un hospital del condado, de un médico privado u otro proveedor quien acepte su tarjeta de Medi-Cal; o puede ingresar a una Organización para el Mantenimiento de la Salud (HMO) que tenga contrato con el Estado de California para proveer todos los cuidados médicos necesarios a las personas elegibles a Medi-Cal que deseen enrolarse a este programa.

La información adjunta a esta carta le ayudará a elegir el tipo de cuidados para la salud que mas le convenga, de acuerdo con sus necesidades y las de sue familia. Favor de leer la información cuidadsomente e indícanos su selección, llenando la tarjeta adjunta y devolviéndola al Departamento de Servicios de Salud. Usted seguirá siendo elegible a los servicios gratuitos de Medi-Cal, cualquiera sea su decision, por el tiempo que continue recibiendo asistencia.

Queremos estar seguros de que usted tiene toda la información que necesita para tomar una decisión. Si tiene algunas preguntas acerca de la información en esta carta, por favor llame al Departamento de Servicios de Salud por nuestra linea directa (llamada gratuita), al 1-800-952-5528. Piénselo cuidadosamente antes de decidir quien le dará los mejores servicios para el cuidado de salud y la de su familia.

Sinceramente,

Elisabeth H. Lyman

Elisabeth Lyman
Deputy Director
Medical Care Standards
Department of Health Services

Adjuntos:

Appendix B

Mailed Choice Brochure
(English/Spanish Version)

California State Department of Health Services
1455 Capitol Mall, Suite 250
Sacramento, Calif. 95814

What's the difference

BETWEEN A MEDI-CAL CARD AND A MEDI-CAL HEALTH MAINTENANCE ORGANIZATION (HMO-PHP)?

¿Cuál es la diferencia

ENTRE UNA TARJETA DE MEDI-CAL Y UN PLAN DE MEDI-CAL (PHP-HMO)?

Two Kinds of Medi-Cal

Medi-Cal is the State's program for people who need help in paying for health care. If you get a county AFDC check or a gold Social Security check, you have a choice to make about your health benefits. You can choose either the monthly Medi-Cal sticker card program, where you locate your own doctor whenever you need one, or a Medi-Cal prepaid plan, where you get all your services from a single health plan each time you need care. These health plans are now called health maintenance organizations, or HMOs, and they have to meet requirements of both the Federal and State governments.

Although HMOs often provide extra services, either form of Medi-Cal can give you the health care that you and your family need.

Dos Clases de Medi-Cal

Medi-Cal es un programa del Estado para personas que necesitan ayuda económica para pagar servicios médicos para el cuidado de la salud. Si recibe un cheque del condado AFDC (Ayuda para Familias con Niños Dependientes) o un cheque dorado del Seguro Social, usted puede decidir acerca de sus beneficios médicos para el cuidado de su salud.

Usted puede escoger, ya sea el programa regular de Medi-Cal, recibiendo mensualmente una tarjeta de identificación que puede usar con el médico privado que usted escoja cuando lo necisite, o un plan prepagado de Medi-Cal, en donde recibe todos los servicios médicos necesarios dentro de un sólo plan de salud, cada vez que necesite de estos servicios. Estos planes de salud se llaman ahora Organizaciones para el Mantenimiento de la Salud o Health Maintenance Organizations (HMOs), y tienen que satisfacer los requerimientos de los gobiernos Federal y del Estado.

Aún cuando HMOs frecuentemente proveén servicios extra, cualquiera de estos dos programas de Medi-Cal, puede darle los servicios para el cuidado de la salud que usted y su familia necesiten.

What you Can Get From Medi-Cal

These are the basic services that both forms of Medi-Cal provide for you:

- Visits to doctor's offices.
- Hospital and nursing home care when ordered by your doctor.
- Special checkups for children under age 21 and treatment if needed.
- Laboratory and X-ray services.
- Mental health services.
- Dental care.
- Chiropractic services.
- Medications.
- Eyeglasses, hearing aids, medical supplies, and medical equipment when ordered by your doctor.

Lo Que Puede Obtener de Medi-Cal

Estos son los servicios básicos que Medi-Cal, en sus dos formas, provée para usted:

- Visitas a la oficina del médico.
- Hospital y casa de convalecencia para enfermos cuando el médico lo ordene.
- Exámenes para niños hasta la edad de 21 años y tratamiento si es necesario.
- Servicios de laboratorio y rayos X.
- Servicios para la salud mental.
- Servicios dentales.
- Servicios quiroprácticos.
- Medicinas.
- Lentes ó anteojos, aparatos para oir suplementos y equipo médico cuando el médico lo ordene.

Advantages and Disadvantages

There are advantages and disadvantages to both kinds of Medi-Cal. You will want to consider them carefully before you decide which kind is best for you and your family.

Included with this brochure is specific information about the HMOs that you may join in your area, including a list of the extra services they provide. As you read the information about the HMOs, here are some things to consider before you decide which kind of Medi-Cal you want:

1. • When you become a member of an HMO, you have to use the HMO's doctors and other services (except if you can't get there in an emergency). • If you have monthly Medi-Cal stickers, you can use any doctor you choose — as long as he or she will take Medi-Cal patients.
2. • When you become a member of an HMO, you sign a contract (enroll) and you have a guaranteed right to medical care. • [illegible] vices can be guaranteed available *only* at your county hospital or other county facilities.
3. • In an HMO, there is a grievance system that is set up to try to solve any problems members have with their health plan's services. • If you have a problem with a doctor or other provider under the regular Medi-Cal system, it's up to you to discuss and settle it with the doctor or provider — or to find another to take care of you.
4. • When you become a member of an HMO, you remain a member as long as you continue to receive your AFDC or gold check. If, for some reason, you become unhappy with the HMO, it is possible for you to disenroll. Getting out of the health plan usually takes approximately 60 days. • With a Medi-Cal sticker card, if you become dissatisfied with your doctor, you can leave him or her and try to find another who will accept Medi-Cal patients.

Ventajas y Desventajas

Los dos programas de Medi-Cal, con etiquetas y prepagado, tienen sus ventajas y desventajas. Usted debe de considerarlos cuidadosamente antes de decidir cuál es el mejor programa para usted y su familia.

Incluida con este folleto es la información específica acerca de los HMOs en su área, con una lista de los servicios extra que proveén a los beneficiarios de Medi-Cal. Cuando lea la información acerca de HMOs, éstas son algunas cosas que debe de considerar antes de decidir qué forma de Medi-Cal desea escoger:

1. • Cuando se subscribe a un HMO tiene que hacer uso de sus médicos y demás servicios (excepto en caso de emergencia cuando la facilidad no sea accesible a Ud.) • Si tiene Medi-Cal con etiquetas puede usar el médico de su preferencia, siempre y cuando el o ella acepte pacientes con Medi-Cal.
2. • Cuando se subscribe a un HMO, es como si firmara un contrato que le garantiza sus derechos a recibir cuidados para la salud. • Cuando tiene Medi-Cal con etiquetas, servicios médicos pueden ser garantizados a su disposición *solamente* en el hospital y otras facilidades de su condado.
3. • En un HMO hay un sistema de quejas que sirve para resolver cualquier problema que un subscriptor pueda tener con los servicios del plan de salud al que pertenece. • Si tiene un problema con el médico u otro proveedor bajo el sistema de Medi-Cal con etiquetas, depende de usted el discutirlo y resolverlo con el médico o proveedor, o encontrar a otro que se haga cargo de usted.
4. • Cuando se subscribe a un HMO, usted sigue siendo miembro por tanto tiempo como continúe recibiendo su cheque AFDC o un cheque dorado. Sin embargo, si por alguna razón usted ya no esta satisfecho con HMO, puede desenrolarse y dejar el plan de salud, un proceso que se lleva aproximadamente 60 días. • Con Medi-Cal con etiquetas, si usted no está satisfecho con su médico puede dejarlo y encontrar otro quien acepte pacientes de Medi-Cal regular.

- When you join an HMO, the HMO will send you a booklet that will tell you where its doctors, pharmacies, and other services are located, what their normal hours are, how to make an appointment for the kind of service you need, and what to do in an emergency. This information can be especially important to you. • There is no similar information package available for regular Medi-Cal, but it is important for you to ask your doctor in advance what to do if your child suddenly runs a fever in the middle of the night.

How to Choose

As long as you continue to receive your AFDC or gold check, you will not have to pay anything for your Medi-Cal benefits — either way. But you should still choose carefully.

For example, if you already have a family doctor who knows you and any health problems you may have, you are probably wise to stay with that doctor if he or she accepts Medi-Cal

5. • Cuando usted se enrola a HMO, esta organización le enviará un libreto que le informará de sus médicos, farmacias, y demás servicios; también le informará a dónde están localizados, cuáles son las horas normales de servicio, cómo hacer una cita y que debe de hacer en un caso de emergencia. Esta información es de mucha importancia para usted. • No hay información similar de Medi-Cal con etiquetas, pero es importante que usted pregunta a su médico antes de que debe de hacer si su niño se le enfermera de repente a la media noche.

Como Escoger

Por el tiempo en que continue recibiendo su cheque de AFDC o un cheque dorado, usted no tendrá que pagar nada por los beneficios de Medi-Cal en cualquiera de sus dos formas. Pero aún así, debe de escoger con mucho cuidado.

Por ejemplo, si usted tiene un médico para toda la familia a quien ven con regularidad y sabe qué problemas de salud tienen, sería más prudente quedarse con el mismo médico, si es que acepta pacientes con las

patients. But, if you do not have a family doctor, or if you can't find a doctor who will accept Medi-Cal patients, you may be better off joining an HMO — so that you will not have to try to find a doctor when you or your child become sick.

In making your choice, be sure to consider your whole family. For example, the State requires each HMO to give children who are plan members a full health examination to detect problems *before* they become serious. (This program is called Child Health Disability Prevention — CHDP.) You can get these exams for your children with a regular Medi-Cal card, but you must find a doctor who is willing to provide the service.

When You Decide

When you have made your choice between the two kinds of Medi-Cal, please fill out the enclosed card. It will help us to get the right Medi-Cal identification card to you as soon as possible.

etiquetas de Medi-Cal. Pero si no lo tiene o no puede encontrar un médico que acepta pacientes con etiquetas de Medi-Cal, sería mejor subscribirse a un HMO y evitar el problema de encontrar a última hora un médico que lo atienda cuando usted o su niño se enferman de repente.

Cuando escoja, asegúrese que toma en consideración la familia entera. Por ejemplo, el Estado requiere de cada HMO que de a los niños (hasta la edad de 21 años) miembros del plan, un completo exámen de salud de acuerdo con el programa de Prevención contra la Incapacidad en la Salud del Niño (Child Health Disability Prevention), para descubrir problemas de salud *antes* de que se conviertan en problemas serios. (Usted puede pedir estos servicios de un proveedor de Medi-Cal regular. El Estado no puede requerir de los médicos privados que lleven a cabo estos exámenes, pero sí pagará por ellos.)

Cuando Usted Decida

Cuando usted haya escogido entre las dos formas de Medi-Cal, por favor complete la tarjeta incluída. Nos ayudará para darle la tarjeta de indentificación de Medi-Cal correcta para usted lo más pronto posible.

Appendix B
HMO Brochure - Rockridge

California State Department of Health Services
455 Capitol Mall, Suite 250
Sacramento, Calif. 95814

Rockridge Health Care Plan

The Rockridge Health Care Plan is a health service system which provides continuing care as well as care for major illness and accidents in its primary health center and in other facilities associated with the health care plan. The plan encourages use of its facilities for health maintenance, early disease detection, and prompt medical treatment.

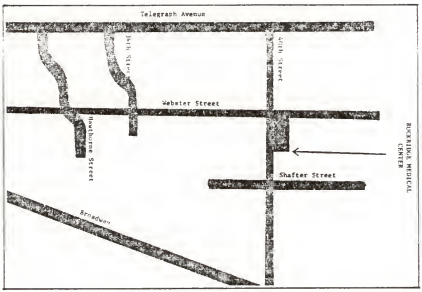
The primary health center is located at 40th and Webster Street. Dental offices and pharmacy are next door.

"ROCKRIDGE" Plan de Cuidados Para la Salud

"Rockridge" Plan de Cuidados para la Salud, es un sistema de servicios para la salud que provee cuidados continuos así como cuidados para enfermedades graves y accidentes en su centro de salud primaria y otras facilidades asociadas con el Plan de Cuidados para la Salud.

El plan anima a los miembros a usar sus facilidades para el mantenimiento de la salud, temprana detección de enfermedades y su tratamiento, lo más pronto posible.

El centro de salud primaria esta localizado en la esquina de Webster y 40th. Las oficinas para el cuidado dental están al otro lado.



Rockridge Service Area Map

Mapa del Area de Servicios Disponibles del Plan de Salud

Primary Health Centers

Medical Offices:
420 40th Street, Oakland

Service Hours:
9:00 a.m.-8:30 p.m., Monday through Friday
9:00 a.m.-4:30 p.m., Saturday
1:00 p.m.-7:00 p.m., Sunday

Services Provided

Medical — Adult medicine, pediatrics, obstetrics and gynecology, dermatology, ophthalmology, optometry, and others by referral.

Dental

Extra Services

Child care with appointment, mid-wife and alternative birth services, and transportation (bus tokens, ambulance, taxi cab fares paid when necessary for services).

Pharmacy

4001 Webster Street (40th and Webster Streets)

24-Hour Emergency Care

Available by calling the plan's emergency telephone number.

For more information, call the health plan at 653-9930 or the Department of Health Services at 1-800-952-5528 (no charge to you).

Centro de Salud Primaria

Oficinas Médicas: 420 - 40th Street, Oakland

Horas de Servicios:

9:00 a.m.-8:30 p.m., Lunes a Viernes
9:00 a.m.-4:30 p.m., Sabados
1:00 p.m.-7:00 p.m., Domingo

Servicios Disponibles

Servicios Médicos — Medicina para adultos, pediatría, obstetricia/ginecología, especialistas para la piel, oftamología, optometría, y otros servicios si son referidos por el médico

Servicios Dentales

Servicios Extras

Cuidado para los niños provisto por la clínica, servicio de partera, clases de educación para la salud, y transportación — servicio de autobús, ambulancia, y carro de sitio gratis cuando sea necesario.

Farmacia

4001 Webster Street (40th and Webster Street), Oakland

Servicios de Emergencia

Para servicios de emergencia, favor de llamar al teléfono del plan de salud.

Para más información, llame al Plan de Salud al numero 653-9930 o al Departamento de Servicios de Salud al número 1-800-952-5528 (llamada gratuita).

Appendix B

Mail Choice Card - Rockridge (Alameda County) English Version

Please take a few minutes to answer these questions:

1. Do you have a regular source of health care? 1) ☐ Yes 2) ☐ No
2. If you or a member of your household is sick, where do you usually go for care?
   1) ☐ Private doctor 2) ☐ County clinic
   3) ☐ County hospital 4) ☐ Emergency room
   5) ☐ Other
3. Do you or a member of your household need medical care now? 1) ☐ Yes 2) ☐ No
4. Had you ever heard of Health Maintenance Organizations (HMOs) before you received this? 1) ☐ Yes 2) ☐ No
5. Have you or a member of your family ever joined an HMO? 1) ☐ Yes 2) ☐ No

Mail back to State Dept. of Health Services — No stamp necessary.

(Vease el otro lado para la version en espanol)

- Please tell us what you have decided about your health care by marking:
  - Box A — Enroll me and my family in an HMO.
  - Box B — I'd like to learn more about HMOs, but keep my sticker card for now.
  - Box C — I'd like to keep my monthly sticker card.

- If you have chosen an HMO, check the box by the plan's name below and tell us how you want to be contacted.

☐ Home Visit ☐ Telephone Call

☐ Rockridge

Here is the choice: (Please give information below for each family member, including yourself.)

Name: Last, First, Middle	Relationship to You?	Sex	Birthday Mo., Day, Yr.	A Enroll Me and My Family in HMO	B Learn More About HMOs	C Monthly Sticker Card
	(Self)					

Print Name	Sign	Date	Phone

Appendix B

Spanish Version

Por favor tómese unos minutos para contestar estas preguntas:

1. ¿Tiene usted un médico de recibir cuidados para la salud regularmente? 1) ☐ Sí 2) ☐ No
2. ¿Si usted o una persona de su casa se enferma, a dónde va, generalmente, por atención médica? 1) Médico privado 2) Clínica del condado 3) Hospital del condado 4) Servicio de emergencia 5) otro
3. ¿Usted o una persona de su casa necesita cuidados médicos ahora? 1) ☐ Sí 2) ☐ No
4. ¿Sabía ya de las Organizaciones para el Mantenimiento de la Salud (HMOs) antes de haber recibido ésta? 1) ☐ Sí 2) ☐ No
5. ¿Nunca ha ingresado, usted o un miembro de su familia, a un HMO? 1) ☐ Sí 2) ☐ No

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- Por favor díganos que ha decidido acerca de los cuidados para su salud, marcando:
  - Cuadro A — Enrolen a mi familia y a mí en un HMO.
  - Cuadro B — Deseo tener más información acerca de un HMO. Por ahora me quedaré con mi tarjeta con etiquetas.
  - Cuadro C — Deseo quedarme con mi tarjeta con etiquetas mensualmente.

- Si usted ha escogido un HMO, marque el cuadro con el nombre del plan y díganos cómo comunicarnos con usted.

☐ ¿Visita en su casa? ☐ ¿Llamada telefónica?

☐ "Rockridge" Plan de Ciudados para la Salud

Regrésela al Departamento de Servicios de Salud del Estado — No necesita estampilla.

Esto es lo que escogí: (Por favor dé la información correspondiente por cada miembro de la familia, incluyendose usted mismo)

Nombre: Apellido, Primero, Segundo	¿Qué Relación a Ud.?	Sexo	Fecha de Nacimiento Mes/Día/Año	A Enrolme en un HMO	B Deseo más información	C Guardaré mi tarjeta

Nombre:
(letra de imprenta) Dirección Ciudad Zona Postal Teléfono

Firma: Fecha: Número de Medi-Cal.
(Favor de copiar los números en el lado izquierdo de su tarjeta, hasta las estrellitas**)

Sample Dual-Choice Presentation
(California Medicaid Program)

Good morning (afternoon). My name is _____. I am here to explain to you how you can receive Medi-Cal benefits if you are determined eligible for aid. Once you are determined eligible for aid, you are entitled to receive health benefits under the Medi-Cal program. I am going to explain the Medi-Cal program now and, at the end of my talk, you will need to tell us how you want to receive your health benefits.

There are two ways to receive Medi-Cal benefits. One way you can receive your health care is by using a monthly Medi-Cal sticker card. Using the sticker card, you must find a doctor, pharmacy, and dentist who will accept the Medi-Cal card and take care of you. The monthly Medi-Cal card will be mailed to you from (Name of issuing agency and location) each month that you are eligible for the cash grant. (If you wish to locate a provider who takes the Medi-Cal card, please call the County Medical Society at _____ or look at the list I will give you.)

You should know that in this area there are (many/few) doctors who take Medi-Cal cards. You should be aware that not all doctors accept Medi-Cal, but the county health facilities always do.

The other way to receive your health care is by joining an HMO or Health Maintenance Organization. Some Health Maintenance Organizations contract with the (Name of state agency) to provide health care to Medi-Cal clients who receive cash grants. Our area does have an HMO to provide services to you, the (Name of HMO). There is no cost to you, if you are determined eligible for the cash grant, for either the (Name of HMO) HMO or the monthly Medi-Cal card. Whether you choose the (Name of HMO) or

the monthly sticker card, you are entitled to the following health services from each:

1. Office visits to the doctor.
2. Hospital or nursing home care.
3. Lab and x-ray services.
4. Mental health services.
5. Prescriptions and medications.
6. Dental care.
7. Eyeglasses, hearing aids, medical supplies, and equipment as ordered by your doctor.
8. Physical, occupational, and other therapy, when your doctor orders it.
9. Special check-ups for children under 21.

Remember that if you choose the monthly sticker card, you must find someone who provides these services and accepts the Medi-Cal monthly sticker card.

If you choose to enroll in the (Name of HMO) it will provide all of these services for you but you must use (Name of HMO) doctors, pharmacies, dentists, and hospitals. You can choose which (Name of HMO) doctor you would like as your family doctor. The (Name of HMO) is located at (Location) and works with (Name of hospitals) hospitals. If you are currently on a treatment program with a doctor and you enroll in (Name of HMO) you will need to transfer your care to a doctor at (Name of HMO) and the plan will help you do this.

(Name of HMO) meets federal and state standards for the provision of medical care. It also offers some additional benefits which are not available with the monthly Medi-Cal sticker card. (Name of HMO) offers midwife and alternative birth services and child care with

appointments.* You also receive a booklet which explains how to use the health plan and obtain your health benefits.

(Name of HMO) also offers 24-hour emergency care which is available by calling the plan's emergency telephone number. If you do enroll in (Name of HMO), you must use the plan's facilities except in an emergency if you are unable to reach the plan. They you can go the nearest emergency facility. With a monthly sticker card you can always receive care at the county hospital.

(Name of HMO) is required to provide children under the age of 21 with child health disability prevention screening, diagnosis, and treatment.

(Some doctors and clinics who accept the monthly Medi-Cal sticker card also provide these services.)

There is no cost to you, if you are determined eligible for the cash grant, for either the (Name of HMO) HMO or the monthly Medi-Cal card.

If you are dissatisfied with the care which you are receiving at (Name of HMO) or with any other aspect of the plan, you can file a complaint with (Name of HMO) and they will attempt to solve your problem. If they cannot solve your problem to your satisfaction, they you can disenroll from (Name of HMO). It will take several months to get a monthly Medi-Cal sticker card after you file your complaint. If you are dissatisfied with the care you are receiving from a doctor, dentist, etc., who takes the monthly Medi-Cal sticker card, you must look for another source of care which takes the monthly sticker card.

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*This section is variable depending on HMO benefit package.

Once you are determined eligible for the cash grant, you will receive a monthly Medi-Cal card if you choose to get the card or a membership card from (Name of HMO) if you choose to receive services from them. You should carry your card with you at all times in case of an emergency. Your choice for the (Name of HMO) HMO or the monthly sticker card is completely voluntary. Your monthly AFDC check, food stamps and right to medical benefits will not be affected whichever way you choose.

These common questions are usually asked in deciding which to receive--the sticker card or the (Name of HMO).

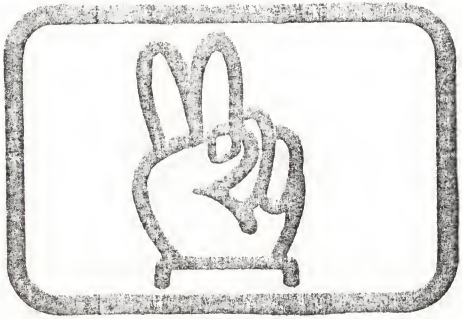
- Where do I get my health care? With the sticker card you can go to any doctor, drug store, or other provider who accepts Medi-Cal. With the HMO you get all your health care from (Name of HMO) except if you can't get there in an emergency.

- How do you know what to do? With the sticker card you should decide which doctors you want to use and find out where they are, if they take Medi-Cal, and what their hours are. With the (Name of HMO) card, (Name of HMO) will send you a booklet which tells you where it is, what its regular hours are and what to do in an emergency. You should be aware that not all doctors accept Medi-Cal, but the county health facilties always do. When you are an HMO member you have the right to receive health care at its facilities whenever medically necessary.

- What if I don't like the health care provider I choose today? If you don't like the services or the care you get with a sticker card, you can talk to your doctor. You may have to locate another doctor who accepts Medi-Cal or you may want to then join (Name of HMO). With the HMO card, (Name of HMO) has a grievance system set up to try to solve your problems and deal with complaints if you don't like the service or care that you get.

- How long do you have to keep the kind of Medi-Cal that you choose today? Well, if you decide later that you would like to join (Name of HMO) and you've chosen a sticker card today, let your worker know or call (Name of HMO) directly. It takes about 45 days to get an HMO card. If you join (Name of HMO) then decide that you would like to get out of it and get a sticker card, you must notify the HMO that you want to leave. It takes several months to change to a sticker card. The pamphlet which you have describes the hours and locations of the (Name of HMO) facilities. Please take a few minutes to look over this material. Then fill out this form that I am passing out. I'll help you complete it if you need help.

The choice is yours!



You may choose:

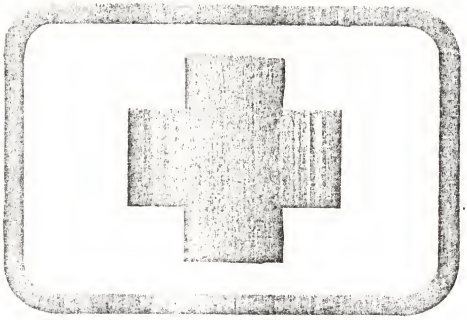
1. To receive a monthly sticker card (you find your own doctors and other providers).
2. To join a Health Maintenance Organization (you get all medically necessary services from the HMO).

Both the monthly sticker card and the HMO card will identify you to receive basic health services, including:

1. office visits to the doctor
2. hospital or nursing home care
3. lab and X-ray services
4. mental health services
5. prescriptions and medications
6. dental care
7. eyeglasses, hearing aids, medical supplies and equipment as ordered by your doctor
8. physical, occupational and other therapy, when your doctor orders it
9. special check-ups for children under 21

Medi-Cal

?	Sticker Card	or	HMO Card
1. Where do I get my health care?	You can go to any doctor, drug store or other provider who accepts Medi-Cal.		You get all your health care from the HMO, except in emergencies.
2. How do I know what to do?	You should decide which doctors you want to use and find out where they are, if they take Medi-Cal, and what their hours are.		The HMO sends you a booklet which tells you: 1. Where it is. 2. What its regular hours are. 3. What to do in an emergency.
3. Do all doctors accept Medi-Cal patients?	Not all doctors accept Medi-Cal, but the county's health facilities always do.		When you are an HMO member, you have a right to receive health care at its facilities whenever medically necessary.
4. What do I do if I don't like the services or care I get?	You can talk to your doctor. You may have to locate another doctor who accepts Medi-Cal.		Each HMO has a grievance system set up to try to solve problems or complaints.
5. How long do I have to keep the kind of Medi-Cal I choose today?	If you decide later that you would like to join an HMO, let your worker know, or call the HMO directly. (It takes about 45 days to get an HMO card.)		If you want to leave you notify the HMO. (It takes about 45 days to change to a sticker card).



Does the HMO in your area provide extra services important to you?

APPENDIX C

Demonstration Descriptions--Choice-Making Scenarios
for Individual (Contra Costa) and Group (Alameda) Presentations;
Example of County-State Agreement for Demonstration

(Examples only; full set of scenarios available from NTIS)

THE PHRED PROJECT

Alameda County North Oakland Office

The Prepaid Health Research, Evaluation, and Demonstration (PHRED) Project is supported by a grant from DHEW's Health Care Financing Administration (HCFA). The objective of the Project is to develop model administrative systems and procedures that can be used by any state which contracts with prepaid health plans for the care of Medicaid (Medi-Cal) beneficiaries.

The overall objectives of the project are to: (1) develop and demonstrate systems, materials, and procedures that will serve to inform properly an to educate Medicaid beneficiaries about their health care alternatives and to motivate a choice between enrollment in a state-contracted PHP and the fee-for-service (private physicians) system of care, (2) to develop and demonstrate systems and methods which will serve to ensure that those who elect enrollment in a prepaid system will have opportunity to express dissatisfaction and to receive clarification, redress, and the option to disenroll, (3) to develop administrative methods and procedures by which a state can monitor the enrollment of beneficiaries into contracting prepaid health plans and the operations of the plan's grievance disenrollment system.

The intention of the demonstrations in your office is to determine which method of informing clients of the Medi-Cal options works best: county employee explanation, plan employee explanation, state employee explanation, audio-visual explanation, or written materials without further explanation. Additionally, the PHRED Project will be assessing Plans' current enrollment practices and a mailing to the beneficiaries served by your office.

To control for variables over time the written materials method will be demonstrated, one day each week at each site. The scheduled demonstration method in progress will be suspended on that day.

Training relevant to the presentation will be given to those staff members concerned shortly prior to the scheduled presentation dates.

The demonstration schedule is as follows:

PHP representative presentation	6/4/79 to 8/11/79
Mailing	8/13/79 to 9/7/79
Current method assessment	9/10/79 to 11/2/79
Eligibility worker presentation	11/5/79 to 1/11/80
State representative presentation	1/14/80 to 3/21/80
Audio-visual presentation	3/24/80 to 5/30/80

THE PHRED PROJECT

East Sacramento Office

The Prepaid Health Research, Evaluation and Demonstration (PHRED) Project is supported by a grant from DHEW's Health Care Financing Administration (HCFA). The objective of the Project is to develop model administrative systems and procedures that can be used by any state which contracts with prepaid health plans for the care of Medicaid (Medi-Cal) beneficiaries.

The overall objectives of the project are to: (1) develop and demonstrate systems, materials, and procedures that will serve to inform properly and to educate medicaid beneficiaries about their health care alternatives and to motivate a choice between enrollment in a state-contracted PHP and the fee-for-service (private physicians) system of care, (2) to develop and demonstrate systems and methods which will serve to ensure that those who elect enrollment in a prepaid system will have opportunity to express dissatisfaction and to receive clarification, redress, and the option to disenroll, (3) to develop administrative methods and procedures by which a state can monitor the enrollment of beneficiaries into contracting prepaid health plans and the operations of the plan's grievance disenrollment system.

The intention of the demonstrations in the East Sacramento Office is to determine which method of informing clients of their Medi-Cal options works best: county employee explanation, or written materials without further explanation. Additionally, the PHRED Project will be assessing Plans' current enrollment practices and a mailing to the beneficiaries served by the East Sacramento Office.

To control for variables over time the written materials method will be demonstrated, one day each week at each site. The scheduled demonstration method in progress will be suspended on that day.

Training relevant to the presentation will be given to those staff members concerned shortly prior to the scheduled presentation dates.

The demonstration schedule is as follows:

State representative presentation	6/4/79 to 8/31/79
Mailing	8/13/79 to 8/7 79
PHP representative presentation	9/10/79 to 11/16/79
Current method assessment	11/19/79 to 1/11/80
Eligibility worker presentation	1/14/80 to 3/21/80
Audio visual presentation	3/24/80 to 5/30/80

If you need any assistance or information regarding prepaid health plans in your area, the toll-free number to the Department of Health Services is 1-800-952-5328.

THE PHRED PROJECT

Orange County Westminster Office

The Prepaid Health Research, Evaluation and Demonstration (PHRED) Project is supported by a grant from DHEW's Health Care Financing Administration (HCFA). The objective of the Project is to develop model administrative systems and procedures that can be used by any state which contracts with prepaid health plans for the care of Medicaid (Medi-Cal) beneficiaries.

The overall objectives of the project are to: (1) develop and demonstrate systems, materials, and procedures that will serve to inform properly and to educate medicaid beneficiaries about their health care alternatives and to motivate a choice between enrollment in a state-contracted PHP and the fee-for-service (private physicians) system of care, (2) to develop and demonstrate systems and methods which will serve to ensure that those who elect enrollment in a prepaid system will have opportunity to express dissatisfaction and to receive clarification, redress, and the option to disenroll, (3) to develop administrative methods and procedures by which a state can monitor the enrollment of beneficiaries into contracting prepaid health plans and the operations of the plan's grievance disenrollment system.

The intention of the demonstrations in your office is to determine which method of informing clients of their Medi-Cal options works best: county employee explanation, plan employee explanation, state employee explanation, audio-visual explanation, or written materials without further explanation. Additionally, the PHRED Project will be assessing Plans' current enrollment practices and a mailing to the beneficiaries served by your office.

To control for variables over time the written materials method will be demonstrated, one day each week at each site. The scheduled demonstration method in progress will be suspended on that day.

Training relevant to the presentation will be given to those staff members concerned shortly prior to the scheduled presentation dates.

The demonstration schedule is as follows:

Eligibility worker presentation	5/14/79 to 7/20/79
Mailing	7/23/79 to 8/17/79
Current method assessment	8/20/79 to 10/12/79
Audio-visual presentation	10/15/79 to 12/21/79
PHP representative presentation	12/24/79 to 3/1/80
State representative presentation	3/3/80 to 5/9/80

If you need any assistance or information regarding prepaid health plans in your area, the toll-free number to the Department of Health Services is 1-800-952-5528.

THE PHRED PROJECT

Florence Office

The Prepaid Health Research, Evaluation and Demonstration (PHRED) Project is supported by a grant from DHEW's Health Care Financing Administration (HCFA). The objective of the Project is to develop model administrative systems and procedures that can be used by any state which contracts with prepaid health plans for the care of Medicaid (Medi-Cal) beneficiaries.

The overall objectives of the project are to: (1) develop and demonstrate systems, materials, and procedures that will serve to inform properly and to educate medicaid beneficiaries about their health care alternatives and to motivate a choice between enrollment in a state-contracted PHP and the fee-for-service (private physician) system of care, (2) to develop and demonstrate systems and methods which will serve to ensure that those who elect enrollment in a prepaid system will have opportunity to express dissatisfaction and to receive clarification, redress, and the option to disenroll, (3) to develop administrative methods and procedures by which a state can monitor the enrollment of beneficiaries into contracting prepaid health plans and the operations of the plan's grievance disenrollment system.

The intention of the demonstrations in your office is to determine which method of informing clients of their Medi-Cal options works best: county employee explanation, plan employee explanation, state employee explanation, audio-visual explanation, or written materials without further explanation. Additionally, the PHRED Project will be assessing Plans' current enrollment practices and a mailing to the beneficiaries served by your office.

To control for variables over time the written materials method will be demonstrated, one day each week at each site. The scheduled demonstration method in progress will be suspended on that day.

Training relevant to the presentation will be given to those staff members designated properly prior to the scheduled presentation dates.

The demonstration schedule is as follows:

Current method assessment	6/4/79 to 7/27/79
State representative presentation	7/30/79 to 10/5/79
PHP representative presentation	10/8/79 to 12/14/79
Mailing	12/17/79 to 1/11/80
Audio-visual presentation	1/14/80 to 3/21/80
Eligibility worker presentation	3/24/80 to 5/30/80

If you need any assistance or information regarding prepaid health plans in your area, the toll-free number to the Department of Health Services is 1-800-952-8529.

THE PHRED PROJECT

East Valley Office

The Prepaid Health Research, Evaluation and Demonstration (PHRED) Project is supported by a grant from DHEW's Health Care Financing Administration (HCFA). The objective of the Project is to develop model administrative systems and procedures that can be used by any state which contracts with prepaid health plans for the care of Medicaid (Medi-Cal) beneficiaries.

The overall objectives of the project are to: (1) develop and demonstrate systems, materials, and procedures that will serve to inform properly and to educate medicaid beneficiaries about their health care alternatives and to motivate a choice between enrollment in a state-contracted PHP and the fee-for-service (private physicians) system of care, (2) to develop and demonstrate systems and methods which will serve to ensure that those who elect enrollment in a prepaid system will have opportunity to express dissatisfaction and to receive clarification, redress, and the option to disenroll, (3) to develop administrative methods and procedures by which a state can monitor the enrollment of beneficiaries into contracting prepaid health plans and the operations of the plan's grievance disenrollment system.

The intention of the demonstrations in your office is to determine which method of informing clients of their Medi-Cal options works best: county employee explanation, plan employee explanation, state employee explanation, audio-visual explanation, or written materials without further explanation. Additionally, the PHRED Project will be assessing Plans' current enrollment practices and a mailing to the beneficiaries served by your office.

To control for variables over time the written materials method will be demonstrated, one day each week at each site. The scheduled demonstration method in progress will be suspended on that day.

Training relevant to the presentation will be given to those staff members concerned shortly prior to the scheduled presentation dates.

The demonstration schedule is as follows:

State representative presentation	6/4/79 to 8/11/79
PHP representative presentation	8/13/79 to 10/19/79
Current method assessment	10/22/79 to 12/14/79
Eligibility worker presentation	12/17/79 to 3/22/80
Mailing	2/25/80 to 3/21/80
Audio-visual presentation	3/24/80 to 5/30/80

If you need any assistance or information regarding prepaid health plans in your area, the toll-free number to the Department of Health Services is 1-800-952-8328.

THE PHRED PROJECT

Pittsburg Office

The Prepaid Health Research, Evaluation and Demonstration (PHRED) Project is supported by a grant from DHEW's Health Care Financing Administration (HCFA). The objective of the Project is to develop model administrative systems and procedures that can be used by any state which contracts with prepaid health plans for the care of Medicaid (Medi-Cal) beneficiaries.

The overall objectives of the project are to: (1) develop and demonstrate systems, materials, and procedures that will serve to inform properly and to educate medicaid beneficiaries about their health care alternatives and to motivate a choice between enrollment in a state-contracted PHP and the fee-for-service (private physicians) system of care, (2) to develop and demonstrate systems and methods which will serve to ensure that those who elect enrollment in a prepaid system will have opportunity to express dissatisfaction and to receive clarification, redress, and the option to disenroll, (3) to develop administrative methods and procedures by which a state can monitor the enrollment of beneficiaries into contracting prepaid health plans and the operations of the plan's grievance disenrollment system.

The intention of the demonstrations in your office is to determine which method of informing clients of their Medi-Cal options works best: county employee explanation, plan employee explanation, state employee explanation, audio-visual explanation, or written materials without further explanation. Additionally, the PHRED Project will be assessing Plans' current enrollment practices and a mailing to the beneficiaries served by your office.

To control for variables over time the written materials method will be demonstrated, one day each week at each site. The scheduled demonstration method in progress will be suspended on that day.

Training relevant to the presentation will be given to those staff members concerned shortly prior to the scheduled presentation dates.

The demonstration schedule is as follows:

Current method assessment	4/16/79 to 6/8/79
PHP representative presentation	6/11/79 to 8/17/79
Mailing	8/20/79 to 9/15/79
State representative presentation	9/17/79 to 11/23/79
Audio-visual presentation	11/26/79 to 2/1/80
Eligibility worker presentation	2/4/80 to 4/11/80

If you need any assistance or information regarding prepaid health plans in your area, the toll-free number to the Department of Health Services is 1-800-952-5528.

THE PHRED PROJECT

Contra Costa County Richmond Office

The Prepaid Health Research, Evaluation and Demonstration (PHRED) Project is supported by a grant from DHEW's Health Care Financing Administration (HCFA). The objective of the Project is to develop model administrative systems and procedures that can be used by any state which contracts with prepaid health plans for the care of Medicaid (Medi-Cal) beneficiaries.

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The intention of the demonstrations in your office is to determine which method of informing clients of their Medi-Cal options works best: county employee explanation, plan employee explanation, state employee explanation, audio-visual explanation, or written materials without further explanation. Additionally, the PHRED Project will be assessing Plans' current enrollment practices and a mailing to the beneficiaries served by your office.

To control for variables over time the written materials method will be demonstrated, one day each week at each site. The scheduled demonstration method in progress will be suspended on that day.

Training relevant to the presentation will be given to those staff members concerned shortly prior to the scheduled presentation dates.

The demonstration schedule is as follows:

Eligibility worker presentation	4/16/79 to 6/22/79
Current method assessment	6/25/79 to 8/17/79
Audio-visual presentation	8/20/79 to 10/26/79
State representative presentation	10/29/79 to 1/4/80
Key Plan representative presentation	1/7/80 to 3/14/80
Mailing	3/17/80 to 4/11/80

If you need any assistance or information regarding prepaid health plans in your area, the toll-free number to the Department of Health Services is 1-800-952-5528.

DEPARTMENT OF HEALTH SERVICES
~~XXXXXXXXXX~~ 455 Capitol Mall, #250
SACRAMENTO, CA 95814
(916) 322-4616

Date: _____

Dear _____ :

The purpose of this letter is to confirm the tentative agreement reached at the _____, 1979 meeting concerning the Prepaid Health Research, Evaluation, and Demonstration (PHRED) Project demonstrations in your county.

The project will commence May 1, 1979 and run through April 12, 1980.

During the implementation and operation of the demonstration, the State will be responsible for the following activities:

1. Describe all data to be collected and supplied to the Department, identify the target population, and provide all reporting formats, time tables, and procedures.

2. Develop and provide to the County a time schedule for each demonstration within the Project prior to the beginning date of the demonstrations.

3. In conjunction with training staff of the County, develop and provide training to all employees of the County participating in the demonstrations, and their supervisors.

4. In conjunction with the County determine required floor space in the demonstration site(s) for each demonstration.

5. Develop or specify and provide to the County at no cost to the County all material to be used during the term of the Project.

6. Assign a State employee as a demonstration worker.

7. Provide technical assistance to the County during the term of the Project to ensure adherance to data collection and research procedures.

8. Consult with the County on demonstration procedures, time tables, and reporting formats, and modify them, as possible within the research design, to have the least possible effect on on-going County operations.

9. Provide the County with a final report on the outcome of the Project.

During the implementation and operation of this Project, _____ County will be responsible for the following activities:

A. Report all cost data associated with the demonstration in a report format specified by the Department and retain such data for no less than one year following the termination of this agreement.

B. Utilize the time schedule developed by the Department and attached to this agreement for performing specific demonstrations within the Project design.

C. Designate the individual office(s) to be used as demonstration site(s), subject to concurrence by the Department, at least 30 days prior to the effective date of the demonstrations.

D. Provide appropriate floor space, as jointly determined by the Department and County within the demonstration site for each demonstration within the Project design.

E. Assign County employee(s) as demonstration workers or as participants in the Project. (Demonstration worker means any County or State employee, or Prepaid Health Plan representative, who directly presents or makes available to the target population applicable material developed for the Project.)

F. Provide a desk, chairs, telephone, and any other work equipment which the County determines is necessary to all demonstration workers.

G. Provide supervision and clerical services for demonstration workers employed by the County.

H. Provide training time for all County workers participating in the demonstrations and their supervisors.

I. Provide for or allow physical renovation of County-owned demonstration sites if necessary. Agreement as to the necessity for renovation shall be secured from both parties prior to the beginning date of each demonstration within the Project and such renovation will be completed prior to the beginning date of appropriate demonstrations.

J. Provide clerical support, as needed, for collection of data and reporting. All data shall be reported in a format specified by the Department.

K. Allow demonstration workers access to demonstration site(s).

L. Provide translation services, if necessary.

In order for the County to receive reimbursement for participation in the Project, the County must strictly adhere to the County claiming procedures for PHRED Project Demonstrations (Attachment A). Additionally, PHRED staff will, at the end of the Project, compare actual costs expended on the Demonstration Project with amounts claimed. Actual costs will be computed by applying the composite cost per hour for each quarter to the total hours reported on the PHRED Choice and Presentation Information Forms (Attachment B). If there are actual costs which have not been paid through the usual process, adjustment will be made by Medi-Cal.

Your cooperation and participation in the demonstrations is greatly appreciated. The significance of our findings, in terms of how the poor are informed of their medical care options, cannot be overstated and your participation in the demonstrations will aid in strengthening whatever conclusions can be drawn.

Sincerely,

Elizabeth W. Owen
Research Specialist
Membership Studies
PHRED Project

EO/tb

Attachments

County Claiming Procedures for PHRED Project Demonstrations

1. Eligibility workers involved in the PHRED Project record time during the time study month to the appropriate AFDC line (A1 or A2, Intake or Continuing, depending upon the action being taken).

2. Each eligibility worker involved in the PHRED Project maintains a supplemental time study which will document the amount of time spent on the PHRED Project which was charged to AFDC. Compile all supplemental time studies and total.

3. Based upon the current quarterly claim, develop a composite cost per hours for AFDC Eligibility Activity. [(DFA 327.2, line A, Column 3+4+5) = Total AFDC hours (323, line A.5) = Composite cost per hour]

4. Multiply composite cost per hour times Total Hours spent on the PHRED Project as documented by the supplemental time study.

5. Enter amount computed in instruction #4 in 325.2, Group III B.1., Personal Services, as a credit to the AFDC Program. This credit will then be carried forward to the DFA 327.2, line A, Column 6.

6. Enter amount computed in instruction #4 in 325.2, Group VI, Extraneous, and identified as PHRED Project.

7. Forward the claim to Medi-Cal with costs identified in Extraneous. Medi-Cal can then make payment to the County.

Duties of the Contractor (County Welfare Department)

1. General

   For all demonstrations, keep and report all data related to cost according to an agreed-upon schedule, using a report format specified by the State; make suggestions and recommendations for improvement in the demonstrations; instruct and train appropriate staff; supervise performance of the demonstrations; allow State reasonable access to county staff for training and monitoring purposes.

2. Specific

   a. For the demonstration using county workers (2 months):
      (1) Assign worker(s) to project; provide for supervision.
      (2) Provide training (State-supplied) for all affected by demonstrations.
      (3) Provide working space and usual work materials and equipment for demonstration worker(s).

   b. For the demonstration using State staff (2 months):
      (1) Provide necessary space and office equipment, including telephone.
      (2) Provide training (State-supplied) for all county workers relating to the demonstration.

   c. For the demonstration using the film or video-tape presentation (2 months):
      (1) Allocate appropriate space (large room for group viewing or smaller space for viewing at individual carrels with cassettes) and facilitate renovation as necessary (State-paid).
      (2) Provide for training (State-supplied) of all affected workers and staff (i.e., for referring EW, supervisors, etc.).
      (3) Supply clerical services (if required by procedure to be agreed-upon) for collection of all choice cards after viewing film.

   d. For the demonstration using written materials alone (2 months):
      (1) Provide training (State-supplied) for all affected EWs and supervisors (plus receptionists, if required by procedure to be agreed-upon).
      (2) Provide for services of EWs or clerks to assure that every beneficiary receives information and returns choice-card during eligibility process.

   e. For the demonstration using PHP staff (2 months):
      (1) Allocate space, equipment and telephone service for staff from PHP(s). (Note: If group intake is employed, no space on-site will be required.)
      (2) Provide for training (State-supplied) of all affected staff so that beneficiary is offered information and referred to PHP representative if interested in enrollment. (Note: In situations in which intake is in group meetings, allow the PHP representative to make brief oral presentations and have intake worker provide similar information about the fee-for-service system.)

(3) Provide for services of either EWs or clericals to assure that each beneficiary is offered information and that all make a choice on choice cards.

Duties of the State

1. General

For all demonstrations, describe all data required and provide a reporting format and schedule; discuss demonstration procedures and modify, as possible within research design, to have the least possible effect on on-going county operations; monitor the progress of all demonstrations; supply materials and cover costs directly related to added requirements.

2. Specific

a. For the demonstration using county workers (2 months):
   (1) Provide training.
   (2) Provide demonstration materials.
   (3) Monitor progress of the demonstration and adherance to research procedures, making suggestions for changes or improvements through supervisors.

b. For the demonstration using state workers (2 months):
   (1) Provide staff.
   (2) Provide training and necessary materials for all EWs to give to eligibles.

c. For the demonstration using the audio-visual presentation (2 months):
   (1) Provide film or video-tape version of presentation as suited to site.
   (2) Provide equipment for viewing.
   (3) Pay for any necessary renovations to county premises to allow viewing.
   (4) Provide necessary written supporting materials.
   (5) Provide for training of all county staff affected by demonstration or relating to it.

d. For the demonstration using written materials alone (2 months):
   (1) Supply all necessary materials.
   (2) Provide training for all county staff disseminating materials and/or collecting choice cards.

e. For the demonstration using PHP staff (2 months):
   (1) Arrange with PHP(s) for the assignment of representatives to the demonstration and for their supervision.
   (2) Provide training and information for all county staff relating to the demonstration.
   (3) Provide directly, and indirectly (from PHPs), all necessary written materials.

APPLICATION PROCESS	DEMONSTRATION PROCESS	FORMS
. Applicant goes to reception desk. If new application or reapplication, receptionist completes Form 10-9, Waiting Room Contact. Applicant is given CA-1 to complete while waiting. Applicant takes a number and waits.		County Form 10-9 CA-1
. Reception desk sees applicants in numerical order. Receptionist goes over CA-1 with applicant. Receptionist completes Form 10-16A for open case check. Receptionist schedules applicant for group intake (usually the next morning if redetermination, clients are scheduled 3 weeks in advance.) Receptionist gives applicant a packet with forms to fill out for group intake and a letter explaining which documents to bring in. (If redetermination this material is mailed out by the E.W.'s.	a) Receptionist distributes Basic Information Form and State Brochure	CA-1 County Form 10-16A Packet Basic Information Form State Brochure CA-2 DFA-285 WR 2.1
. Applicant goes home.		
. Applicant arrives for group intake at 8:30 a.m. (Redetermination is scheduled for 1:30 p.m.). Group intake worker conducts session!		

GROUP INTAKE DEMONSTRATION STRATEGY

APPLICATION PROCESS	DEMONSTRATION PROCESS	FORMS
. Applicants turn in all forms to group intake worker.	c) Group intake worker collects Basic Information Forms.	Choice and Presentation Form (CPIF)
	d) Group intake worker distributes Choice and Presentation Information Form (CPIF).	Presentation AV Aid for demonstration worker for all demonstrations
	e_1) Group intake worker tells applicants to fill in the Choice portion of the CPIF.	
	* No presentation will be made. The worker collects the Choice and Presentation Information Form. OR	
	e_2) Group intake worker explains that applicants have a choice for receiving Medi-Cal benefits. Worker then shows 5 min. film. After film is completed, worker instructs applicants to complete the Choice portion of the CPIF. Worker collects the CPIF OR	
	e_3) Group intake worker gives the presentation on Medi-Cal choices. After presentation, worker instructs applicants to complete the Choice portion of the CPIF. Worker collects the CPIF. OR	
	e_4) Group intake worker introduces PHP representative. Representative gives presentation. Representative leaves room. Worker instructs applicant to complete choice portion of the CPIF. Worker collects the CPIF. OR	
	e_5) Group intake worker introduces State Field Representative. State employee gives presentation, instructs applicants to complete the Choice portion of the CPIF and collects the CPIF.	
. Applicants go to waiting room	f) Group intake worker completes the demonstration portion of the choice and presentation information Form (CPIF).	

OFFICE: NORTH OAKLAND
COUNTY: ALAMEDA

GROUP INTAKE DEMONSTRATION STRATEGY

APPLICATION PROCESS	DEMONSTRATION PROCESS	FORMS
Eligibility workers call applicants by name and proceed to interview as necessary.		
Applicant goes home.	g) Clerical receives Choice Information Presentation Form from group intake worker, and staples to Basic Information Form for each applicant. h) Clerical batches Basic Information Forms under the Choice and Presentation Information Form and places in PHRED box. i) PHRED Field Representative collects forms weekly.	

COUNTY: CONTRA COSTA

INTAKE AND REEVALUATION

CHOICE OFFERED ON FILM PRESENTATION

FILM PROCESS	DEMONSTRATION PROCESS (FILM)	FORMS
1. Division Chiefs (Intake and Re-evaluation) will determine time slots for PHRED. Those clients falling into PHRED time slots will be scheduled 15 minutes early for appointments.		State Brochure Basic Information Form (BIF)
2. E.W.s of those clients designated as PHRED participants will be notified.		
3. Clients will report to receptionist.		
4. Receptionist will give PHRED clients a State brochure package, which will include a Basic Information Form (BIF) and Choice Presentation Information Form (CAPIF).		Choice and Presentation Information Form (CAPIF)
5. Receptionist will request that PHRED designated clients go to the film area to observe a short film on Medi-Cal Dual Choice.		
6. Receptionist will explain to clients that they are requested to fill out the BIF and the Choice Presentation Information Form(CAPIF) after viewing the movie and to give them to E.W.		
7. Client returns to waiting room after viewing film.	A. E.W. calls client B. E.W. conducts intake or reevaluation interview. C. At end of interview, E.W. collects BIF and CAPIF. D. E.W. completes BIF and demonstration portion of CAPIF. E. Client leaves. F. E.W. assembles all PHRED forms, staples them together and places them in PHRED box.	

RICHMOND OFFICE

COUNTY: CONTRA COSTA

INTAKE AND CHOICE OFFERED ON BROCHURE HAND OUT DAY

HAND OUT PROCESS	DEMONSTRATION PROCESS (BROCHURE)	MATERIALS
1. Client reports to receptionist. 2. Receptionist checks to see if client is AFDC. 3. If client is PHRED AFDC, a package will be given to client* 4. Receptionist will ask client to review Brochure, fill out the Choice portion of the Choice and Presentation Information Form and give it to their worker.	A. E.W. does regular interview. B. At close of interview, E.W. will collect the CPIF and BIF. C. E.W. will complete demonstration portion of the CPIF. D. Client leaves E. E.W. assembles all PHRED forms, staples them together and puts them in PHRED box.	State Brochure Basic Information Form (BIF) Choice and Presentation Information Form (CPIF) PHRED Box

*Welfare office is willing to give the package out to only PHRED designated AFDC clients but not to all AFDC clients coming in the office on brochure day.

APPLICATION PROCESS	DEMONSTRATION PROCESS (E.W. PRESENTATION)	FORMS
. Applicant reports to Receptionist. Applicant is given a CA-1 to fill out. . Applicant fills out forms and returns them to Receptionist. . Receptionist forwards forms to Data Processing, where applicants information is checked to see if there is any current or History files. . Applicant forms are then placed in screening box. Applicants name and the time are entered in the screening daily log. . Intake screener calls applicants for interview. During interview potential classification is determined. . Screener then calls Receptionist for appointment. If applicant is AFDC, screener will indicate this to Receptionist. . At the time the appointment is made if the applicant is placed in one of the time slots that have been designated as PHRED, the Receptionist will schedule the interview 15 minutes earlier than usual and notify the screener that the applicant is PHRED designated		

APPLICATION PROCESS	DEMONSTRATION PROCESS (E.W. PRESENTATION)	FORMS
. If a client is PHRED designated, the screener will include a basic information form to the regular package of forms given the client.		Basic Information Form (BIF)
. The screener will also give the client a State Brochure and ask them to review it prior to their scheduled intake interview.		Brochure
. Applicant leaves.	A. Client checks in with Receptionist.	Choice and Presentation Information Form (CAPIF)
	B. Receptionist notifies E.W.	
	C. E.W. calls client. Reviews forms, interviews client.	
	D. E.W. gives Dual Choice Presentation.	Flip Chart
	E. Gives client the CAPIF and asks them to fill out and sign the choice portion.	
	F. E.W. fills out the demonstration portion of the CAPIF.	
	G. Client leaves.	
	H. E.W. assembles all PHRED forms-staples them together and places them in PHRED box.	

APPLICATION PROCESS	DEMONSTRATION PROCESS (PHP REPRESENTATIVE PRESENTATION)	FORMS
. Applicant reports to receptionist. Applicant is given a CA-1 to fill out. Applicant fills out forms and returns them to receptionist. . Receptionist forwards forms to Data Processing, where applicants information is checked to see if there is any current or History files. . Applicant forms are then placed in Screening box. Applicants name and the time are entered in the screening daily log. . Intake screener calls applicants for interview. During interview potential classification is determined. . Screener then calls receptionist for appointment. If applicant is AFDC, screener will indicate this to receptionist. . At the time the appointment is made if the applicant is placed in one of the time slots that have been designated as PHRED, the receptionist will schedule the interview 15 minutes earlier than usual and notify the screener that the applicant is PHRED designated. . If a client is PHRED designated, the screener will include a Basic Information Form to the regular package of forms given the client.		Basic Information Form (BIF)

APPLICATION PROCESS	DEMONSTRATION PROCESS (PHP REPRESENTATIVE PRESENTATION)	FORMS
The screener will also give the client a State Brochure and ask them to review it prior to their scheduled intake interview. Applicant leaves.	A. Client checks in with receptionist. B. Receptionist notifies PHP representative. C. PHP representative calls client, Reviews BIF. D. PHP representative will ask client if they object to having interview taped. Whenever possible interviews will be taped. E. PHP representative gives Dual Choice Presentation. F. Gives client the CAPIF and asks them to fill out and sign the choice portion. G. PHP representative fills out demonstration section of the CAPIF. H. Client returned to waiting room. I. If client is late for interview, PHP representative will give presentation after E.W. interview. J. PHP representative assembles all PHRED forms, staples them together and places them in PHRED box. along with daily tapes.	Brochure Choice and Presentation Information Form (CAPIF) Tape Recorder, tapes

APPLICATION PROCESS	DEMONSTRATION PROCESS (STATE REPRESENTATIVE PRESENTATION)	FORMS
. Applicant reports to receptionist. Applicant is given a CA-1 to fill out. . Applicant fills out forms and returns them to receptionist. . Receptionist forwards forms to Data Processing, where applicants information is checked to see if there is any current or History files. . Applicant forms are then placed in Screening box. Applicants name and the time are entered in the screening daily log. . Intake screener calls applicants for interview. During interview potential classification is determined. . Screener then calls receptionist for appointment. If applicant is AFDC, screener will indicate this to receptionist. . At the time the appointment is made if the applicant is placed in one of the time slots that have been designated as PHRED, the receptionist will schedule the interview 15 minutes earlier than usual and notify the screener that the applicant is PHRED designated.		

EW APPLICANT

PPLICATION PROCESS

CHOICE OFFERED DURING INTAKE

APPLICATION PROCESS	DEMONSTRATION PROCESS (STATE REPRESENTATIVE PRESENTATION)	FORMS
If a client is PHRED designated the screener will include a Basic Information Form to the regular package of forms given the client.		Basic Information Form (BIF)
The screener will also give the client a State Brochure and ask them to review it prior to their scheduled intake interview.		Brochure
Applicant leaves.	A. Client checks in with receptionist. B. Receptionist notifies State Representative. C. State representative calls client. Reviews BIF. D. State representative gives Dual Choice Presentation. E. Gives client the CAPIF and asks them to fill out and sign the choice portion. F. State representative fills out the demonstration section of the CAPIF. G. Client returned to waiting room. H. State representative assembles all PHRED forms, staples them together and retains them. I. If client is late for interview, State representative will give presentation after E.W. interviews.	Choice and Presentation Information Form (CAPIF)

RE-EVALUATION PROCESS	DEMONSTRATION PROCESS (E.W. PRESENTATION)	FORMS
. Files for re-evaluation pulled per schedule. . Files reviewed, appointments scheduled. . Necessary forms and appointment time and date mailed to client. . If client appointment is scheduled in one of the time slots designated for PHRED, the appointment will be scheduled 15 minutes earlier then usual, and the E.W. involved notified. . If a client is PHRED designated, a Basic Information Form, and a State Brochure (with an explanation that the dual Medi-Cal Choice will be discussed at the interview) will be added to the package to be mailed to the clients.	A. Client checks in with receptionist. B. Receptionist notifies E.W. C. E.W. calls client, reviews forms, interviews client. D. E.W. gives Dual Choice presentation. E. Gives client the CAPIF and asks them to fill out and sign the choice portion. F. E.W. fills out the demonstration section of the CAPIF. G. Client leaves. H. E.W. assembles all PHRED forms-staples them together and places them in PHRED box.	Basic Information Form (BIF) State Brochure Explanation Memo Choice and Presentation Information Form (CPIF)

CHOICE OFFERED DURING RE-EVALUATION

RE-EVALUATION PROCESS	DEMONSTRATION PROCESS (PHP REPRESENTATIVE)	FORMS
1. Files for re-evaluation pulled per schedule. 2. Files reviewed, appointments scheduled. 3. Necessary forms and appointment time and date mailed to client. 4. If client appointment is scheduled in one of the time slots designated for PHRED, the appointment will be scheduled 15 minutes earlier than usual. 5. If a client is PHRED designated, a Basic Information Form, and a State Brochure (with an explanation memo) will be added to the package to be mailed to the client.	A. Client checks in with receptionist. B. Receptionist notifies PHP Representative. C. PHP representative calls client, reviews BIF. D. Asks client if they may tape interviews. E. Gives client Dual Choice Presentation. F. Gives client the CAPIF and asks them to fill out and sign the choice portion. G. PHP representative fills out the demonstration portion of the CAPIF. H. Client returned to waiting room. I. PHP representative assembles all PHRED forms, staples them together and places them in PHRED box. J. PHP representative places tapes used for that day in PHRED box at end of each day.	Basic Information Form (BIF) State Brochure Explanation Memo Choice and Presentation Information Form (CAPIF)

RICHMOND OFFICE
COUNTY: C[illegible]A COSTA
RE-EVALUAT[illegible]

CHOICE OFFERED [illegible]NG RE-EVALUATION

4/27/79

RE-EVALUATION PROCESS	DEMONSTRATION PROCESS (STATE PRESENTATION)	FORMS
1. Files for re-evaluation pulled per schedule. 2. Files reviewed, appointments scheduled. 3. Necessary forms and appointment time and date mailed to client. 4. If client appointment is scheduled in one of the time slots designated for PHRED, the appointment will be scheduled 15 minutes earlier than usual. 5. If a client is PHRED designated a Basic Information Form and a State Brochure (with an explanation memo) will be added to the package to be mailed to the clients.	A. Client checks in with receptionist. B. Receptionist notifies State representative. C. State Representative calls client, reviews BIF. D. Gives Dual Choice Presentation. E. Gives client the CAPIF and asks them to fill out and sign the choice portion. F. State representative fills out the demonstration portion of the CAPIF. G. Client returned to waiting room. H. State representative assembles all PHRED forms, staples them together and retains them.	Basic Information Form (BIF) State Brochure Explanation Memo Choice and Presentation Information Form (CAPIF)

APPENDIX D

Data Collection Forms

(Examples only; full set available from NTIS)

State of California—Health and Welfare Agency

Department of Health Services

BASIC INFORMATION FORM FOR MEDI-CAL BENEFITS

Appendix D: Data Collection Forms
Item 1
Basic Information Form for Medi-Cal Benefits

PLEASE PRINT YOUR NAME AND ADDRESS IN THE SPACES BELOW

1 NAME: _____ (Last) _____ (First) _____ (Middle)

2 ADDRESS _____ (Street Number) _____ (Street or Road) _____ (City)

_____ (County) _____ (Zip)

3. PHONE NUMBER _____ (Area Code) _____ (Number)

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOU AND YOUR FAMILY

4. What is your birthdate? _____ (Month) _____ (Day) _____ (Year)

5. What is your sex? . . . . . 1) ☐ Female
2) ☐ Male

6. What is your current marital status? (check one) . . . . . 1) ☐ Married
2) ☐ Divorced
3) ☐ Separated
4) ☐ Widowed
5) ☐ Single
6) ☐ Other _____

7. What language is spoken in your home? (check one) . . . . . 1) ☐ English
2) ☐ Spanish
3) ☐ Other _____

8. What is your ethnic group identity? (check one) . . . . . 1) ☐ Asian
2) ☐ Black
3) ☐ Filipino
4) ☐ Hispanic
5) ☐ Native American
6) ☐ White
7) ☐ Other _____

9. What is the highest grade you completed in school? (circle one)
0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 more than 16

10. For how many children are you seeking aid? (circle one)
0 1 2 3 4 5 6 7 8 9 10 11 12 more than 12

11. How old is your oldest child? (circle one, unborn = 0)
0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 more than 19

12. If you have more than one child, how old is the youngest? (circle one, unborn = 0)
0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 more than 19

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUR YOUR HEALTH CARE:

13. Do you have a regular source of health care now? 1) ☐ Yes
2) ☐ No

14. If you or a member of your household is sick, where do you usually go for care? 1) ☐ Private Doctor
2) ☐ County Clinic
3) ☐ County Hospital
4) ☐ Emergency Room
5) ☐ HMO/PHP
6) ☐ Other _____

15. Do you or any of the persons for whom you are seeking aid need medical care now? 1) ☐ Yes
2) ☐ No

16. Have you ever heard of Health Maintenance Organizations (HMOs/PHPs) before? 1) ☐ Yes
2) ☐ Not Sure
3) ☐ No

17. Have you or someone in your family ever belonged to a HMO/PHP before? 1) ☐ Yes
2) ☐ Not Sure

Appendix D: Data Collection Forms
Item 2a
Choice and Presentation Form for Medi-Cal Benefits - Contra Costa County

State of California—Health and Welfare Agency

CHOICE AND PRESENTATION INFORMATION FORM
FOR MEDI-CAL BENEFITS

See Reverse for Privacy Information Practice Act Notification

DIRECTIONS: Please fill in the following information about your health care decision. REMEMBER: a choice should be made for each member of the family for whom you are applying. If you choose to enroll in a Medi-Cal Health Maintenance Organization (HMO/PHP), check the box labeled HMO.

If you choose a Medi-Cal monthly sticker card, check the box labeled CARD.

TO THE STATE DEPARTMENT OF HEALTH SERVICES: I have made a choice between receiving a Medi-Cal monthly sticker card and enrolling in a Medi-Cal Health Maintenance Organization (HMO/PHP). If I (we) are eligible for Medi-Cal, I wish to receive health care benefits for myself and the family members for whom I am authorized to sign as I have indicated in the box below.

	1. NAME (Please Print) Last	First	Middle	2. Relation To You:	3. Decision Check One: HMO	CARD	4. MEDI-CAL NUMBER	5. BIRTHDATE Mo. Day Year	6. SEX M=Male F=Female
A				Self					
B									
C									
D									
E									
F									
G									

IF YOU HAVE CHOSEN AN HMO/PHP, CHECK THE BOX BY THE PLAN'S NAME AND TELL US HOW YOU WANT TO BE CONTACTED

7. ☐ Contra Costa Key Plan

8. Contact me . . . . . 1) ☐ At home
2) ☐ By phone

9. Do you have any other Health Insurance? 1) ☐ Yes 2) ☐ No
Company: _____

PLEASE ANSWER THESE QUESTIONS ABOUT YOUR DECISION:

10. Was your decision the same for all members of your family? . . . . . 1) ☐ Yes 2) ☐ No

If you marked no, why was it different for some members?

_____

11. In making your decision, did you think health care in an HMO/PHP would be . . .
Better than what you receive now . . . . . 1) ☐
About the same as you receive now . . . . . 2) ☐
Not as good as you receive now . . . . . 3) ☐

PRINT YOUR NAME AND ADDRESS BELOW:

Last	First	Middle	Street Number	Street/Road	City
Sign Name	Date		County	Zip	Phone Number

COUNTY PROJECT USE ONLY BELOW THIS LINE

1. Office (City Location):
   1) ☐ Pittsburg 2) ☐ Richmond
   3) ☐ Oakland 4) ☐ Sacramento Co.
   5) ☐ East Valley 6) ☐ Fresno
   7) ☐ Orange 8) ☐ ☐

2A. Type of Case:
   1) ☐ Intake 2) ☐ Re-evaluation
   3) ☐ Add Code Change 4) ☐ Other

2B. Family Case Number: _____

3. Has client received aid in the last 6 months?
   1) ☐ Yes 2) ☐ No

4A. Was printed material received by client?
   1) ☐ In Advance 2) ☐ Day of Presentation

4B. Did client report reading the material?
   1) ☐ Yes 2) ☐ No

5. Did the client require a translator to understand the written or oral presentations?
   1) ☐ Yes 2) ☐ No

6. Date of Presentation: ☐☐ Mo. ☐☐ Day ☐☐ Year

7. Presentation Setting
   1) ☐ Individual Presentation
   2) ☐ Group 3) ☐ Couple 4) ☐ Other

8. Type of Presentation
   1) ☐ Printed Material 2) ☐ EW
   3) ☐ HMO Rep 4) ☐ AV (Film)
   5) ☐ State Worker 6) ☐ None
   If none, explain: _____

ITEMS 9–13, COUNTY, STATE, HMO REP PRESENTATIONS ONLY:

9. Presentation Started _____ am pm

10. Presentation Ended _____ am pm

11. Total Presentation Time (In Min.) ..... ☐☐☐

12. Total County EW Time (In Min.) ..... ☐☐☐

13. Total County Clerical Time ..... ☐☐☐

14. Presentation made by: _____

MIC 739 (4/79)

Please take a few minutes to answer these questions:

1. Do you have a regular source of health care?
   1) ☐ Yes 2) ☐ No
2. If you or a member of your household is sick, where do you usually go for care?
   1) ☐ Private doctor 2) ☐ County clinic
   3) ☐ County hospital 4) ☐ Emergency room
   5) ☐ Other
3. Do you or a member of your household need medical care now? 1) ☐ Yes 2) ☐ No
4. Had you ever heard of Health Maintenance Organizations (HMOs) before you received this?
   1) ☐ Yes 2) ☐ No
5. Have you or a member of your family ever joined an HMO? 1) ☐ Yes 2) ☐ No

Mail back to State Dept. of Health Services — No stamp necessary.

(Vease el otro lado para la version en espanol)

- Please tell us what you have decided about your health care by marking
  - Box A — Enroll me and my family in an HMO.
  - Box B — I'd like to learn more about HMOs, but keep my sticker card for now.
  - Box C — I'd like to keep my monthly sticker card.
- If you have chosen an HMO, check the box by the plan's name below and tell us how you want to be contacted.
  - ☐ Home Visit ☐ Telephone Call
  - ☐ Healthcare

Here is the choice: (Please give information below for each family member, including yourself.)

Name Last, First, Middle	Relationship to You?	Sex	Birthday Mo./Day/Yr.	A Enroll in an HMO	B Learn More About HMOs	C Monthly Sticker Card
	(Self)					

Print Name	Sign	Date	Phone

Por favor tómese unos minutos para contestar estas preguntas:

1. ¿Tiene usted un médico de recibir cuidados para la salud regularmente? 1) ☐ Sí 2) ☐ No
2. ¿Si usted o una persona de su casa se enferma, a dónde va, generalmente, por atención médica?
   1) Médico privado 2) Clínica del condado
   3) Hospital del condado 4) Servicio de emergencia 5) otro
3. ¿Usted o una persona de su casa necesita cuidados médicos ahora? 1) ☐ Sí 2) ☐ No
4. ¿Sabía ya de las Organizaciones para el Mantenimiento de la Salud (HMOs) antes de haber recibido ésta? 1) ☐ Sí 2) ☐ No
5. ¿Nunca ha ingresado, usted o un miembro de su familia, a un HMO? 1) ☐ Sí 2) ☐ No

---

- Por favor díganos que ha decidido acerca de los cuidados para su salud, marcando:
  - Cuadro A — Enrolen a mi familia y a mí en un HMO.
  - Cuadro B — Deseo tener más información acerca de un HMO. Por ahora me quedaré con mi tarjeta con etiquetas.
  - Cuadro C — Deseo quedarme con mi tarjeta con etiquetas mensualmente.

- Si usteo ha escogido un HMO, marque el cuadro con el nombre del plan y díganos cómo comunicarnos con usted.
  - ☐ ¿Visita en su casa? ☐ ¿Llamada telefónica?
  - ☐ Grupo de Plan de Servicios para la Salud "Healthcare"

Regrésela al Departamento de Servicios de Salud del Estado — No necesita estampilla

Esto es lo que escogí. (Por favor dé la información correspondiente por cada miembro de la familia, incluyendose usted mismo)

Nombre Apellido Primero Segundo	¿Qué Relación a usted?	Sexo	Fecha de Nacimiento Mes, día, año	A Enviame más información	B Llamen más información	C Guardaré mi tarjeta

Nombre _____
(letra de imprenta) Dirección Ciudad Zona Postal Teléfono

Firma: _____ Fecha _____ Número de Medi-Cal _____

(Favor de copiar los números en el lado izquierdo de su tarjeta, hasta las estrellitas**)

State of California—Health and Welfare Agency

PRESENTATION RESULTS REPORT

Department of Health Services

Name of Rep: _____ Name of Plan: _____ Method: _____ Date: _____

(1) a. Street b. City	(2) Street Number	(3) Apt. Number	(4) Person Home? Yes/No	(5) a. Name of Person Contacted b. Medi-Cal Number	(6) Eligible for PHP Yes/No	(7) Presented PHP Information	(8) Presentation Made to Whom	(9) Refusal at Presentation by Whom/Why	(10) Number of Encounters	(11) Number of Persons in Household	(12) Time Started (Ex. 12:15 P.M.)	(13) Time Ended (Ex. 12:30 P.M.)	(14) Time to Travel (Ex. 010 Min.)	(15) a. Phone Number (If Available b. Notes (Explain Nos. in 8 & 9 and Discrepancy in 10 & 11)
a. _____				a. _____										a. _____
b. _____				b. _____										b. _____
a. _____				a. _____										a. _____
b. _____				b. _____										b. _____
a. _____				a. _____										a. _____
b. _____				b. _____										b. _____
a. _____				a. _____										a. _____
b. _____				b. _____										b. _____
a. _____				a. _____										a. _____
b. _____				b. _____										b. _____
a. _____				a. _____										a. _____
b. _____				b. _____										b. _____

Appendix D: Data Collection Forms
Item 2: Presentation Results Report

MC 7110 (12/79)

(9)

State of California—Health and Welfare Agency

Appendix D: Data Collection Forms
Item 3a
Phone Follow-Up Information Form

Department of Health Services

PHONE FOLLOW-UP INFORMATION FORM (PFIF)

I
Completed Follow-Up ☐
II
Mailer Current in-Office ☐
III
Enrolled ☐
Not Enrolled ☐

(To be used to collect demographic, choice factor, comprehension, and verification data)

INSTRUCTIONS TO THE INTERVIEWER: Fill in as much information as possible before the contact. When using the probe/comment response, circle the appropriate category and write in phrase/question. Make sure that the proper sections are completed for each individual.

Medi-Cal Number _____ Phone ____-____-____

SECTION I — ALL PERSONS

Hello, is this Mr./Mrs./Ms. _____? My name is _____, I am with the Department of Health Services.

1. Recently you were contacted ☐ 1) by mail ☐ 2) at home ☐ 3) at the Social Service office ☐ 4) Other _____ about joining a pre-paid health plan. You were asked to choose between a PHP and your regular Medi-Cal card. *Probe/Comment* _____ 1. ____

2. I have down here that you want to:
   ☐ A) Join a/ _____ PHP with _____ Other members of your family. Is this correct?
      ☐ 1) Yes, continue
      ☐ 2) No, *Probe/Comment* _____ 2A ____
   ☐ B) Stay with regular Medi-Cal. Is this correct?
      ☐ 3) Yes, continue
      ☐ 4) No, *Probe/Comment* _____ 2B ____

I would really appreciate it if you would take a few minutes and discuss your decision with me. The Department of Health Services is very interested in improving how health care is provided to you. One important way that we can do that is by getting your opinions.

3. Is this all right with you?
   ☐ 1) Yes, continue
   ☐ No, then *Probe: Is there some other time that I could call back that would be more convenient for you?*
      ☐ 2) Yes, take time and date/ _____
      ☐ 3) No, thank respondent for time and say good-bye 3 ____

SECTION II — MAIL RESPONDENTS ONLY

First, Mr./Mrs./Ms. _____, I'd like to ask you two questions about the mail packet that you received from the department.

4. What did you think you had to do when you got the mailing?
   ☐ 1) Enroll in a plan ☐ 2) Get more information
   ☐ 3) Send back card to stay on Medi-Cal ☐ 4) Nothing ☐ 5) Other 4. ____

5. Did the mailing help you?
   ☐ 1) Yes, *Comment:* _____
   ☐ 2) No, *Comment:* _____
   ☐ 3) Other, *Comment:* _____ 5 ____

SECTION III DEMOGRAPHICS – MAIL, CURRENT METHOD ONLY

Now, Mrs. / Ms. / Mr. _____, I'd like to ask you some general questions about you and your family.

5. Are you the head of the household?
   ☐ 1) Yes – ask questions in "YOU" format
   ☐ 2) No – ask questions in "HEAD OF HOUSEHOLD" format and
   PROBE: Who is? _____ 5. _____

7. How old are you/head of household? _____ years 7. _____

8. What is your/head of household's marital status?
   ☐ 1) married ☐ 2) divorced ☐ 3) single ☐ 4) separated ☐ 5) widowed ☐ 6) other 8. _____

9. What was your/head of household's highest grade completed in school? _____ years 9. _____

10. How many children are in the household? _____ children 10. _____

11. How old is the youngest child? _____ years 11. _____

12. How old is the oldest child? _____ years 12. _____

13. What language is spoken in your home? ☐ 1) English ☐ 2) Spanish ☐ 3) Other: _____ 13. _____

14. What would you say is your ethnic background?
   ☐ 1) Asian ☐ 2) Black ☐ 3) Filipino ☐ 4) Hispanic
   ☐ 5) Native American ☐ 6) White ☐ 7) Other _____ 14. _____

SECTION IV. A CHOICE FACTORS – HEALTH, ALL PERSONS

Next, Mrs. / Ms. / Mr. _____, I'd like to ask you about you and your family's health.

15. Do you have a family doctor right now?
   ☐ 1) Yes
   ☐ 2) No, then *PROBE: Where do you get most of your care right now?* _____ 15. _____

16. How satisfied are you with the care you are receiving from _____? Would you say you are:
   ☐ 1) Very Satisfied ☐ 2) Satisfied ☐ 3) So So ☐ 4) Dissatisfied ☐ 5) Very Dissatisfied
   Comment: _____ 16. _____

17. How many times have you/head of household seen a doctor in the last year? _____ times 17. _____

18. How many times have other members of the household seen a doctor in the last year? _____ times 18. _____

19. How many times have you/head of household been hospitalized in the last year? _____ times 19. _____

20. How many times have other members of your household been hospitalized in the last year? _____ times 20. _____

21. Do you or any members of your household need medical care right now?
   ☐ 1) Yes ☐ 2) No *Probe/Comment:* _____ 21. _____

SECTION IV.B. CHOICE FACTORS – DECISION: ALL PERSONS

The next set of questions is about your decision to:
☐ Join a PHP ☐ Stay with regular Medi-Cal

22. Had you ever heard of prepaid health plans before you were contacted?
☐ 1) Yes ☐ 2) No *Probe/Comment:* _____ 22 _____

23. Have you or anyone in your household ever joined a PHP before?
☐ 1) Yes ☐ 2) No *Probe Comment:* _____ 23 _____

24. What would you say is the main reason why you decided to
A ☐ Join a PHP? _____ 24 A _____
B *PROBE: Was it important to you that all of the services were under one roof?*
☐ 1) Yes ☐ 2) No _____ B _____
C *PROBE: What other reasons were important to you?* _____ C _____
D ☐ Stay with regular Medi-Cal? _____ D _____
E *PROBE: Was it important to you to choose your own doctor?*
☐ 1) Yes ☐ 2) No _____ E _____
F *PROBE: What other reasons were important to you?* _____ F _____

25. What would you say is the most important thing that
A ☐ PHPS should do for you? _____ 25 A _____
B ☐ Regular Medi-Cal should do for you? _____ B _____

SECTION V. VERIFICATION – ENROLLEES ONLY

Now I'd like to check with you on some things that have or will be happening with your enrollment.

26. Has anyone from the health plan called or come to see you to ask if you have any questions about services?
A. Yes ☐ 1) Phone verification ☐ 2) Home verification ☐ 3) Other _____
B. No ☐ 4) 26 _____

27. Have you received a plan booklet explaining the services available?
☐ 1) Yes ☐ 2) No *Comment:* _____ 27 _____

28. Do you understand that joining the plan was completely voluntary and that you don't have to enroll to keep your food stamps or aid?
☐ 1) Yes ☐ 2) No *Comment:* _____ 28 _____

29A. Do you understand that during the first 30 days of membership you can disenroll (get out) for any reason?
☐ 1) Yes ☐ 2) No *Comment:* _____ 29 A _____

29B. Do you understand that after the first 30 days you can disenroll if you are dissatisfied after you use the plan's grievance system?
☐ 1) Yes ☐ 2) No *Comment:* _____ B _____

30. Did anyone check to see if you were under a doctor's care?
☐ 1) Yes ☐ 2) No *Comment:* _____ 30 _____

31. Do you understand that after your enrollment begins you can't go back to your current doctor unless he or she is on the list?
☐ 1) Yes ☐ 2) No *Comment:* _____ 31 _____

32. Your enrollment will probably be effective _____, you will know because you won't get your Medi-Cal card and the plan will send you an ID card instead. Until then, do you know how to get health care?
☐ 1) Yes ☐ 2) No *Advise:* _____ 32 _____

SECTION VI COMPREHENSION QUESTIONS – ALL RESPONDENTS

Code 1 = Yes
2 = No

The last thing I'd like to do is see how well WE presented information about health care to you by asking you some questions about PHPs and regular Medi-Cal. Just answer TRUE if you think the question is true, or FALSE if you think the question is false. *Probe/Comment.*

33. T F Pre-paid health plans are part of Medi-Cal — 33. ____

34. T F Both regular Medi-Cal and pre-paid Medi-Cal provide basic health care at no cost to you — 34. ____

35. T F People who are eligible for Medi-Cal may choose between regular Medi-Cal and pre-paid Medi-Cal — 35. ____

36. T F Sometimes PHPs offer extra services that regular Medi-Cal doesn't. — 36. ____

37. T F People who use regular Medi-Cal have to use the same doctor all the time. — 37. ____

38. T F If you are using pre-paid Medi-Cal, you must go to that plan's facilities except in emergencies when you can't get there. — 38. ____

39. T F People on Medi-Cal who go to PHPs are guaranteed health care by the plan. — 39. ____

40. T F PHPs allow their members to go anywhere they want for health care. — 40. ____

41. T F People using regular Medi-Cal must find their own doctors. — 41. ____

42. T F It may take approximately 60 days to disenroll from a pre-paid health plan. — 42. ____

Thank you very much Ms. / Mrs. / Mr. _____ for your time and cooperation.

You've been very helpful. Just one more thing before I go, I'd like to check and see if I have your correct address. Is it still _____

43. ☐ 1) Yes
☐ 2) No, get correct address. — 43. ____

COMMENTS.

_____

_____

_____

_____

44. INTERVIEWER: _____ — 44. ____

45. DATE: _____ — 45. ____ / ____ / ____

46. TIME: _____ — 46. ____ : ____

47. Number of Tries: _____ — 47. ____

48. Amount of Interview Time: _____ — 48. ____ Minutes

DEPARTMENT OF HEALTH SERVICES
[redacted] 455 Capitol Mall, Room 250
CRAMENTO, CA 95814
(916) 322-4616

Appendix D: Data Collection Forms
Item 3b
Mail Choice Follow-Up Letter

Recently you were given information about Medi-Cal stickers and Medi-Cal health maintenance organizations at the Social Services Office. You were asked to choose between joining a prepaid health plan (PHP-HMO) and your regular Medi-Cal stickers. On the form you marked that you wanted to join

We have attempted to reach you by telephone, but have been unable to do so. We would like you to help us learn more about how the Medi-Cal Program is working by completing the enclosed questionnaire. Please fill it out and mail it back to us, within five days, in the self-addressed stamped envelope.

This will have no effect on your Medi-Cal benefits, but it will help us to improve the Medi-Cal Program.

Sincerely,

Suzanne Hutchins

Suzanne Hutchins
PHRED Project

Enclosures

State of California—Health and Welfare Agency

Appendix D: Data Collection Forms
Item 24
Mail Choice Follow-Up Questionnaire

Department of Health Services

FOLLOW-UP QUESTIONNAIRE

NAME _____ NUMBER _____

Recently you were contacted at the Social Services office about joining a prepaid health plan. You were asked to choose between a PHP and your regular Medi-Cal card.

The form that you signed states that you want to join a prepaid health plan. Is this correct? ___ 1) Yes ___ 2) No

Next, we'd like to ask you about you and your family's health.

Do you have a family doctor right now?

___ 1) Yes

___ 2) No, then where do you get most of your care right now? _____

_____

How satisfied are you with the care you are now receiving? Would you say you are

___ 1) Very Satisfied ___ 2) Satisfied ___ 3) So-So ___ 4) Dissatisfied ___ 5) Very Dissatisfied

Comment: _____

How many times have you/head of the household seen a doctor in the last year? _____ times

How many times have other members of the household seen a doctor in the last year? _____ times

How many times have you/head of the household been hospitalized in the last year? _____ times

How many times have other members of your household been hospitalized in the last year? _____ times

Do you or any members of your household need medical care right now?

___ 1) Yes ___ 2) No Comment: _____

The next set of questions is about your decision to join a prepaid health plan.

Had you ever heard of prepaid health plans before you were contacted?

___ 1) Yes ___ 2) No Comment: _____

Have you or anyone in your household ever joined a PHP before?

___ 1) Yes ___ 2) No Comment: _____

What would you say is the main reason why you decided to join a PHP _____

_____

Was it important to you that all of the services were under one roof?

___ 1) Yes ___ 2) No Comment: _____

What other reasons were important to you? _____

What would you say is the most important thing that PHPs should do for you? _____

Now we'd like to check with you on some things that have or will be happening with your enrollment.

Has anyone from the health plan called or come to see you to ask if you have any questions about services?

A. Yes ___ 1) Phone ___ 2) Home visit ___ 3) Other _____
B. No ___ 4)

Have you received a plan booklet explaining the services available?

___ 1) Yes ___ 2) No Comment: _____

Do you understand that joining the plan was completely voluntary and that you don't have to enroll to keep your food stamps or AFDC?

___ 1) Yes ___ 2) No Comment: _____

Do you understand that after the first 30 days of membership you can disenroll (get out) for any reason?

___ 1) Yes ___ 2) No Comment: _____

Do you understand that after the first 30 days you can disenroll if you are dissatisfied after you use the plan's grievance system?

___ 1) Yes ___ 2) No Comment: _____

Did anyone check to see if you were under a doctor's care?

___ 1) Yes ___ 2) No Comment: _____

Do you understand that after your enrollment begins you can't go back to your current doctor unless he or she is on the list?

___ 1) Yes ___ 2) No Comment: _____

Do you know that you won't get your Medi-Cal card and the plan will send you an ID card instead. Until then, do you know how to get health care?

___ 1) Yes ___ 2) No Comment: _____

The last thing I'd like to do is see how well WE presented information about health care to you by asking you some questions about PHPs and regular Medi-Cal. Just circle TRUE if you think the question is true, or FALSE if you think the question is false.

Comment: _____

T F Prepaid health plans are part of Medi-Cal.

T F Both regular Medi-Cal and prepaid Medi-Cal provide basic health care at no cost to you.

T F People who are eligible for Medi-Cal may choose between regular Medi-Cal and prepaid Medi-Cal.

T F Sometimes PHPs offer extra services that regular Medi-Cal doesn't.

T F People who use regular Medi-Cal have to use the same doctor all the time.

T F If you are using prepaid Medi-Cal, you must go to that plan's facilities except in emergencies when you can't get there.

T F People on Medi-Cal who go to PHPs are guaranteed health care by the plan.

T F PHPs allow their members to go anywhere they want for health care.

T F People using regular Medi-Cal must find their own doctors.

T F It may take approximately 60 days to disenroll from a prepaid health plan.

APPENDIX E

Instruction Manual, Data Collection Forms
for Health Plans

(Not included; available from NTIS)

APPENDIX F

Reports of Pretests of Instruments

(Not included; available from NTIS)

APPENDIX G

Field Experience/Observation of PHP Marketing Practices

SUMMARY: Field Experience/Observation of PHP Marketing Practices

The quality of care provided by a PHP is not a factor in this report, and is not to be impugned by any element of this report. I feel that it is vital to make this disclaimer before I go any further, as much of what is to follow may adversely reflect on the PHPs represented by the enrollers whose activities I observed.

In each instance, the representative was to some extent intimidated by my presence--some more so than others. Some representatives responded very positively to my reassurances and were able to enroll clients, others were unable to relax and may have suffered financial loss because of the effects of the stress.

The overall impression I received was that a person had to be highly motivated, either by monetary compensation and incentives offered by the PHP, or by the need for a job, in order to be successful as a door-to-door enroller. Many of the reps had a great deal of experience in sales, although none intended to stay in sales forever.

The success of a representative depends on the willingness to "sell the product" including the "hard sell" approach, facing open hostility, and pounding the pavement for long hours, sometimes without a break, rest-stop, or meal all day. The sheer "guts" required to keep on knocking on doors day after day, week in and week out in the worst parts of town is vital to the success of a representative, but it cannot be compensated for by money, because of the toll such work takes on the body, mind, and spirit of the person.

The success of this marketing method, is, in turn, dependent upon the character, personality, and ethics of the representative. This could work very much to the disadvantage of the PHP, because of the low salary (even including the widely fluctuating commission) and the lack of job-security (quota-systems preclude security: a bad month may be your last month), and the high turnover rate. These factors tend to make it highly unlikely that the PHPs will be able to attract highly ethical employees.

The attitude of the representative toward the work was heavily influenced by the rate of pay. Some had worked for other PHPs and the stated reason for leaving was for better pay and/or incentives. None of the representaties admitted that it might have been a question of not meeting the plan's quota. Their attitude about the plan they worked for was apparently of very little concern; they usually expressed the feeling that one plan is much like another, as one product is much like any other.

The widest variation in attitudes was toward the clients/consumers. Some representatives maintained a neutral stance, and made no comment

either about the clients or the welfare system. Other reps were very vocal in their dislike for the clients (one representative would not enter their homes for fear of carrying away "bugs") and for the clients' dependence upon welfare (some of the reps stated that they would "even stay in sales forever" rather than "go on welfare"). I observed only one rep who was actively involved in caring for the clients (the rep had taken in a destitute young couple, had fed them, and given them money, and provided them with an address in order to secure emergency aid while establishing residency).

The techniques used to make the presentation ranged from the "hard sell" with rapid-fire questions and repeated demands for responses, to the "glad hand" with its smiles and dialectal catch-phrases and conversational chit-chat about babies, the weather, astrological signs, and national sports.

Some reps preferred to "work the food stamp office," but for a variety of reasons. The most obvious was the preselection of eligible clients. The desire for this preselection, however, varied from a desire to avoid facing possibly hostile clients to a desire to have a "sure thing." The techniques employed at the food stamp office were among the most blatantly unethical, and personally embarrassing that I observed. One rep even asked me to interview a Spanish-speaking client in order to get the information for a later home visit. Some of the reps followed a client from the food stamp office to the bus stop or to their car (one actually ran after them). In each instance the rep continued to talk to the client right up to the time they drove away; in some instances requiring rudeness on the part of the client in order to get away.

My observation of some of the reps doing follow-ups of leads obtained from lists of fee-for-service users of the plan's facilities or from other undefined sources found a very high (50 percent or more) "no show" rate. Even when a rep called in advance to confirm the appointment, less than half responded to the knock on the door. This lack of response was also seen in the number of doors knocked on without any response (as many as 80 percent did not answer), and the large number of immediate "I don't want any" responses when the door was opened (about half of those who answered). In my opinion, this constitutes a tremendous waste of time, energy, and money, and serves to reinforce the active hostility of the general public toward the health plans which in turn require a "hard sell" approach in order to "sell" enough to make the quota. It's a vicious cycle endlessly repeated.

The only observation of presentations made either in the welfare office or the plan's membership services office were extremely limited by the rather widely-spaced appointments. Even in these environments the "no show" rate was 50 percent. The number of enrollments per contact was apparently very high, but no mention was made of retention rate. The attitude of the representatives in these locations was more relaxed and more positive. They used fewer pressure tactics and allowed the clients

more time to review the printed materials and to ask questions. The only complaint the reps in this setting had was the lack of commission-incentives for the large number of enrollments per month.

Conclusion

Random door-to-door canvassing of poverty areas is only as effective as the salesmanship of an individual representative. It is unorganized, inefficient, expensive, and does not relate in a positive way, if at all, to the quality of services provided by a particular plan, nor to the values of the concept of prepaid health plans in general.

-- Joanne Coogan
August 31, 1979

APPENDIX H

Proposal for Implementation of Dual Choice Method

DEPARTMENT OF HEALTH SERVICES
1980–81 FISCAL YEAR
BUDGET CHANGE PROPOSAL DETAIL

DIVISION: Medical Care Standards SECTION: Eligibility Standards

BRANCH: Eligibility REPORTING UNIT CODE: 805 – 320

SHORT TITLE: Eligibility/PHP Unit

Personal Services	Person Years	Salary Range	C.Y. Amount	B.Y. Amount
Staff Services Manager I	1.0	$1,958-2,362		$23,496
Associate Governmental Program Analyst	4.0	$1,782-2,149		$85,536
Office Assistant II	1.0	$ 804-1,048		$ 9,648

Subtotal, Salaries and Wages		$118,680
– Salary Savings (5%)		5,934
Net Total, Salaries and Wages		$112,746
+ Staff Benefits (29.1%)		32,809
Total Personal Services		$145,555
Operating Expenses:*		$ [illegible]
General Expense		
Communications		[illegible]
Rent		13,375
Travel		[illegible]
Printing		[illegible]
Equipment		
Other (specify)		
Total Operating Expenses		$ [illegible]
EDP (Detail attached)		
Administrative Overhead (38.3%)		$ 55,740
Total Expenditures		$[illegible]
Source of Funds		
General Fund		$ 76,560
Federal Funds		$ 65,218
Other (specify)		

*See other side for standardized costs

FINANCE LETTER PROPOSAL
Medi-Cal Dual Choice Unit

Summary/Recommendation

Establish a new unit within Medi-Cal Eligibility Branch to implement the PHRED demonstrated marketing method in the county welfare offices in which county staff would offer clients a choice in receiving health care services at the time of eligibility determination and redetermination. The unit would be responsible for all Departmental liaison with the AFDC cash grant staff and the dual choice process in the counties served by PHPs.

Problem

AB 1693, 1978, strengthened by AB 1128 and SB 702, in 1979, mandates the Department to provide information to Medi-Cal beneficiaries about Medi-Cal delivery system alternatives, in areas in which alternatives exist, during the eligibility determination process in the county welfare offices. Additionally, the law authorizes the Director to require the counties "to inquire as to whether the beneficiary wishes to choose a particular alternative." Other sections of the law abolish the prevalent practice of door-to-door solicitation of enrollments for Medi-Cal prepaid health plans as of 31 December 1979, with a one-year waiver possible on a plan-by-plan finding of fact basis. (One additional year, only, of waiver is possible, effectively ending this problem-ridden marketing method by 31 December 1981.) (Legal cites: Welfare and Institutions Code, Section 14016.5, 14404, 14405, 14408(d).)

Background

The Department, with the understanding of the Legislature and the health plans, has delayed implementation of these mandates, pending the results of the marketing and enrollment demonstrations of the Prepaid Health Research, Evaluation, and Demonstration (PHRED) Project, which was funded to develop the methods by which the Department will replace door-to-door solicitation. Final evaluation of the demonstration results will not be available until mid-summer; however, the Project's on-going analyses of data from its seven demonstration sites in welfare offices in Northern and Southern California show a consistent HMO-PHP choice by approximately 18 percent of those presented with information about a fee-for-service card and enrolling in a Medi-Cal PHP. The 18 percent Medi-Cal PHP choice closely parallels the 20 percent of California's total population presently enrolled in HMOs or PHPs. It indicates the program's size, currently static with about 120,000 beneficiaries enrolled, would expand if the information and choice were offered universally in all welfare offices in PHP service areas.

Cost data from the Project indicate the Department could save program dollars in two ways by implementing this dual choice for Medi-Cal beneficiaries at eligibility. The savings would come from lower individual enrollment costs ($11.61 in welfare offices) over the very expensive door-to-door process in which every new enrollment costs a conservatively estimated $40. This cost is currently paid by the health plans from the administrative portion of their capitation rates. If it were no longer an expense, the Department could either decrease the capitation rate by the complete amount saved or direct the

plans to use a portion of the savings to increase benefits and thus attract more members. Attracting more members would increase the second area of savings, the $4.87 per enrollee, per month, the Department saves in estimated lower costs to take care of AFDC beneficiaries in prepaid health plans. Even without increased benefits, however, PHRED projects an increase in enrollments over the number currently being enrolled by the plans when the welfare office methods are totally in place.

Alternatives

1. Do nothing, and maintain the status quo.

2. Have PHP marketing representatives come into the welfare offices to provide information about their plans and enroll those interested.

3. Implement the law on a minimal basis and distribute written information through printed folders.

4. Have State staff make presentations of information and request choices during eligibility determination and redetermination in the county offices.

5. Have specially trained county staff (one person per office) make presentations of information and request choices during eligibility and redetermination.

Discussion of Alternatives

1. Because of the legal limits on door-to-door solicitation it is not possible to maintain the status quo for long. Data from the Project indicate the dual choice in the welfare offices is the only viable alternative with which the Department can replace solicitation and maintain plan viability and program growth. The process cannot be implemented overnight in the more than 70 welfare offices in the State currently in areas served by PHPs. It will take some time to phase-in fully. Thus, to meet the time constraints of the law ending door-to-door solicitation, the Department must begin now.

2. Although having the PHPs do the marketing might appear simpler and perhaps more productive of enrollments because of the enthusiasm expected of sales representatives from the plans, there are several difficulties which are likely to prove counter productive: (1) Because of the ever-present danger of misrepresentation, actual or merely alleged, it would be necessary to have monitors (State or county personnel) in each site to be sure that presentations of information and choice were given objectively. Thus, both the plans and the State would be bearing costs for the marketing. (2) The hostility of county welfare department workers toward the PHP program, a legacy of past scandals and client problems, has been documented again and again, most recently by PHRED. If this alternative were implemented, the workers would not accept the choice presentation of the PHP representative as objective and would likely advise their clients against joining.

3. PHRED's data on the results of the use of printed materials to present the choice indicate an average of about four percent choice for HMOs/PHPs across the seven sites, with a range of less than one percent to five percent. Even the higher number would not be enough to guarantee program viability, and would definitely not afford growth opportunity. Thus, while there might be some enrollment resulting, this inexpensive method, unfortunately, could not replace door-to-door solicitation.

4. Using specially trained and dedicated (in the workload sense) county workers or using State field representatives to present the choices in the welfare offices would cost virtually the same amount. While the State staffing would afford maximum control to the Department in this rather sensitive area, it would cause more disruption to the existing eligibility determination process. Presentations could not be made as frequently by State workers as they would be responsible for "circuit-riding", covering several offices. Clients would have to wait for presentations or return to the offices. Further, most welfare offices do not have meeting rooms of sufficient size for a once-a-day presentation.

5. The recommended alternative is discussed below.

Recommendation

The fifth alternative, placement of the dual choice presentation responsibility on specially trained county staff, is recommended as the most feasible and effective method to meet the mandates of the law and to enhance the growth of a cost-containing and cost-saving program. After special training and with monitoring from the new unit, the cash-grant Medi-Cal worker in each office will be able to serve as a resource for all PHP eligibility problems as well as making consistent, objective presentations of the dual choice information. To support the presentation, the State will provide a general information printed folder and choice form; the plans in the area will supply copies of their marketing materials for distribution. All new eligibiles/applicants will be directed to the dual choice presentations, which may be made to large or small groups as individual office facilities and procedures dictate. Redetermination applicants will either attend the group presentation or be given the written materials and choice forms only.

Workload

There are currently 72 welfare offices co-located with current PHP service areas. With full implementation, presentations could be made to 435,000 applicants representing 1.2 million potential beneficiaries each year. Workload estimates for county staff are attached separately. For staff of the new dual choice unit in the Medi-Cal Eligibility Branch workload is summarized below:

1. Three Associate Government Program Analysts would function as monitors for the counties in which PHPs are located. One would handle Los Angeles County, only, because of the number of health plans and social services offices in that county. The other two would divide up the remaining Southern California and Northern

California counties between them. These analysts would be responsible for:

a. Negotiating agreements with the counties.

b. Implementing regulations and procedures through the Department of Social Services which has primary responsibility for the AFDC eligibility process.

c. Training county workers and overseeing the implementation of the process in each office affected in the county.

d. Maintenance of a close relationship with area health plans for early notice of changes in health plan services or locations.

e. Periodic verification of a sample of enrollees or fee-for-service care choosers to determine the objectivity, consistency, and thoroughness of the county workers' presentations.

f. Solutions of any cash-grant Medi-Cal eligibility problems that might arise in the offices or the counties, generally.

2. The fourth AGPA would function in-house:

a. Developing model procedures and implementing regulations with the DSS.

b. Working out similar (to the extent possible) agreements with the Social Security Administration for the offering of dual choice information to the SSI/SSP recipients.

c. Developing printed material.

d. Developing and maintaining a management information system.

3. In addition to supervision of the above tasks and workers, the Staff Services Manager I would provide liaison with the PHP Branch and with the Office of Alternative Health Systems concerning the development of new contracts with PHPs and those pilot projects which involve enrollment.

4. The Office Assistant will provide usual secretarial services and travel arrangements and will maintain the inventory of printed materials, supplying each office as required.

Savings

The cost of establishing a monitoring unit within the Department would be approximately $140,000. County administrative costs are estimated at $1,608,000. PHRED Project demonstrations to date show that dual choice presentations in the 72 welfare offices within PHP areas can generate sufficient HMO enrollments to replace door-to-door solicitation and increase

HMO enrollment by approximately 7 percent per month. Reduction of capitation rates and shift of fee-for-service costs to HMO savings should result in a $3.3 million savings per annum over and above the $1.7 million cost of the unit and the additional county staff. (See attached implementation cost and enrollment estimates.)

Impact

For each presentation a choice would be made for 2.75 family members. Assuming an 18 percent choice for an HMO/PHP, 150,727 enrollments would result. Although these new enrollments will generate a savings by shifting their health care from the fee-for-service sector to the prepayment mode, the major savings which would materialize would result from the reduction of the marketing costs currently paid by the Department to prepaid health plans. This payment is difficult to distinguish because it is lumped into the administrative component of the capitation rate, but we can estimate the amount by studying the plan-reported costs for new enrollments. (See attached fiscal display.)

The establishment of a core unit of State employees to monitor the PHP/HMO dual presentations by county workers will effectively:

1. Increase enrollments in prepaid health plans.

2. Open a communication channel with counties, thereby alleviating many of the misperceptions surrounding the PHP program and aiding in the early detection of problems.

3. Generate a savings of approximately $3,300,000 per annum (see attached fiscal display).

4. Replace the narrowly focused and unmonitorable door-to-door solicitation method curently employed by most prepaid health plans.

5. Meet the legal mandates currently in statute.

Prepaid health plan contractors have expressed support for eliminating door-to-door solicitation as soon as possible. Counties are reluctant to assume additional duties for each eligibility worker but would accept State staff, or State-funded county workers, offering the dual choice. Consumer groups have largely been indifferent to the PHRED demonstrations but are generally supportive of the dual choice concept.

Depiction of County Costs

Assumptions

1. There will be four daily presentations per office about one-half hour plus two hours for presentation preparation, forms inventory and ordering, and processing paperwork to register clients in the appropriate system. (Because Alameda County has a single group meeting per day, the three welfare offices in that county will require only two hours per day.)

2. There are 69 welfare offices co-located with PHP service areas plus the three welfare offices in Alameda County.

3. Medi-Cal worker costs plus administrative overhead are averaged statewide for those counties in which PHPs are located. The cost is $21.61 per hour. Source is the FY 78/79 Cumulative WACC Report.

Computations

2 hours per day x 22 days per month x 12 months =	528 hrs
4 hours per day x 22 days per month x 12 months =	1,056 hrs
528 hours x 3 welfare offices (Alameda) =	1,584 hrs
1,056 hours x 69 welfare offices =	72,864 hrs
(72,864 + 1,584 hours) x $21.61 per hour =	$1,608,821

Total Costs

Eligibility/PHP Unit	$ 141,778
County Staff	1,608,821
Total Costs	$1,750,599

FULL YEAR IMPLEMENTATION
Fiscal Display

AFDC Eligibles 1/	900,000
AFDC Applications Per Annum	1,200,000
AFDC Cases (Intake + Redetermination)	435,000
Potential HMO Choices (at 18%)	78,300
Potential Line Items (x 2.75)	215,325
Potential Enrollment (70%) 2/	150,727
Potential Enrollments	150,727
Current Disenrollment Rate (4% per month)	56,640
Net Enrollment Increase	94,087
Average Monthly Enrollment Increase	7,840

Savings

FFS Savings of New Enrollments 3/ ($4.87 per head per month)	$ 458,170

Marketing Cost Savings 4/

Capitation Rate Component for Marketing:
$39.22 ÷ 12 mos. = $3.27

PHP AFDC Population:
109,250

Add New Enrollments:
109,250 + 7,840 = 117,090
monthly average enrollment

117,090 x $3.27 x 12 = $4,594,612
annual capitation rate reduction

Marketing Cost Savings: $4,594,612 - $1,750,599 (BCP costs)	$2,844,013
Total Estimated Savings	$3,302,183

1/ PHP counties only. CHS 10/01/79.

2/ Potential enrollment is indicated at 70 percent due primarily to determination of ineligibility subsequent to the presentation of the dual choice.

3/ FFS savings for new enrollments is based on capitation rates as health care costs at 14 percent below FFS costs for AFDC population.

4/ Marketing cost savings represent real dollar savings to PHPs and the Department through rate reduction/redirection. The savings is estimated on data supplied via current method evaluation by the PHRED Project supported by self-reported PHP costs of $39.22 per enrollment. (In other contexts, plans have reported costs of $45-$50 per person enrolled.)

This bill would revise that provision to prohibit such solicitation after December 31, 1979, except as authorized by the department, on a plan-by-plan basis, as specified.

The people of the State of California do enact as follows.

SECTION 1. Section 14016.5 of the Welfare and Institutions Code is amended to read:

14016.5. The director shall require that, at the time of determining or redetermining the eligibility of a Medi-Cal beneficiary who resides in an area served by a prepaid health plan and is eligible to enroll in such a plan, the county shall inform the Medi-Cal beneficiary of options available to him regarding methods of receiving Medi-Cal benefits and shall inquire whether the beneficiary wishes to choose any particular method.

SEC. 2. Section 14300 of the Welfare and Institutions Code is amended to read:

14300. The department shall conduct a public hearing at least 30 days prior to the execution of an initial contract with a prepaid health plan and within 120 days prior to the renewal of a prepaid health plan contract to hear and receive evidence on the ability of the prepaid health plan to fulfill its responsibilities under the contract. The hearing shall be conducted in the county within which the prepaid health plan is located, or in the case of a prepaid health plan situated in more than one county, in the county where the largest number of Medi-Cal beneficiaries are enrolled in the plan.

Notice of the time, date, and place of the hearing shall be mailed to the following:

(a) The prepaid health plan applying for the contract or contract renewal.

(b) Medi-Cal beneficiaries enrolled in the prepaid health plan subject to the hearing.

(c) Any interested party who requests notification of public hearings conducted pursuant to this section.

The department shall present evidence and make a finding of fact as to the ability of the prepaid health plan to comply with its previous and proposed contract obligations.

No contract shall be renewed unless the department makes a finding based upon the evidence presented at the public hearing, including evidence presented by the department, that the prepaid health plan has complied substantially with its contract obligations.

SEC. 3. Section 14301 of the Welfare and Institutions Code is amended to read:

14301. (a) The department shall determine, by actuarial methods, prospective per capita rates of payment for services provided under this chapter for Medi-Cal beneficiaries enrolled in a prepaid health plan. The rates of payment shall be determined annually, shall be effective no later than the first day of July each

subdivision (a) to reflect such change. During such period of time as is required to redetermine the per capita rates, payment to a prepaid health plan of the per capita rates in effect at the time such change occurred shall be considered interim payments and shall be subject to increase or decrease, as the case may be, effective as of the date on which such change is effective.

(d) The obligations of a prepaid health plan shall be changed only by contract or contract amendment wherein payment for the changes, whether payment results in an increase or decrease in the prior per capita rates paid to a prepaid health plan, shall be determined in accordance with this section and paid to affected prepaid health plans.

(e) Nothing contained in this section shall be construed as removing from a prepaid health plan the risk of beneficial or adverse effects, including inflation, which normally result from contracting to furnish health services.

SEC. 4. Section 14405 of the Welfare and Institutions Code is amended to read:

14405. The director shall make available such information as is necessary to enable Medi-Cal beneficiaries to exercise an informed choice in receiving benefits under this chapter. For this purpose each prepaid health plan shall provide marketing material to the director for distribution to all prospective enrollees in the plan's service area. Such marketing material shall include the following:

(a) A description of all services and benefits provided by the prepaid health plan.

(b) The location of facilities where benefits and services are provided.

(c) The hours and days when services are available at each of the facilities.

(d) The names of and addresses where each primary care physician, dentist, optometrist, or psychologist provides health services to enrollees of the prepaid health plan.

(e) The names and addresses of each hospital which has agreed to provide health services to the enrollees.

(f) Names and addresses of each pharmacy providing pharmaceutical services to the enrollees.

(g) Transportation arrangements, both routine and emergency, offered by the prepaid health plan.

(h) Any other information as the department may require.

SEC. 5. Section 14408 of the Welfare and Institutions Code is amended to read:

14408. (a) Notwithstanding the provisions of Section 14115 and except as otherwise prohibited by law, a prepaid health plan which has entered into a contract with the department pursuant to this chapter may make the benefits known to potential enrollees by methods approved by the department.

(b) No prepaid health plan or marketing organization shall

engage in marketing activities prior to written approval by the department. All marketing activities and procedures shall be approved by the department prior to being used by a prepaid health plan or marketing organization. The department may approve, disapprove, or withdraw approval of any marketing activity or procedure. The department shall require the discontinuance of any marketing activity or procedure for which the department withdraws approval.

The prepaid health plan shall be responsible for all presentations by their official representatives and for their ethical and professional conduct.

(c) All printed or illustrated material prepared by the prepaid health plan for dissemination to enrollees or to prospective enrollees shall be submitted to the department prior to such dissemination. The department shall acknowledge receipt of the printed or illustrated material within five days, and shall approve or disapprove such material for dissemination within 60 days after the date of notification that the material has been received. The department may withdraw approval of such material previously approved and order its dissemination discontinued. Where the department notifies the prepaid health plan of its disapproval or withdrawal of approval, the prepaid health plan shall have the right to meet and confer with the director or his designee and demonstrate the purpose and reasonable basis for the distribution of such material to enrollees and potential enrollees.

(d) On or after January 1, 1980, door-to-door solicitation of Medi-Cal enrollees shall not be permitted except by authorization of the department. Prior to authorizing a continuation of door-to-door solicitation, the department shall make a written finding of fact, for each plan for which the department proposes to permit a continuation of door-to-door solication, that alternative methods of marketing and enrollment are insufficient to guarantee enrollment stability for the prepaid health plan. The authorization to continue door-to-door solicitation shall apply to each plan for which the department has made such a finding of fact and shall continue for a period not to exceed one year, except that the department may extend such authorization an additional year by making a new finding of fact. In permitting door-to-door solicitation of Medi-Cal enrollees, it is the intent of the Legislature that the department shall develop alternative enrollment procedures to maximize enrollment stability and growth in prepaid health plans.

O

federal Public Health Service Act, and which has more than one million enrollees, of whom less than 10 percent are Medi-Cal enrollees, information required pursuant to this subdivision shall consist of reports required to be made to the Department of Health, Education and Welfare pursuant to Title XIII of the federal Public Health Service Act.

SEC. 4. Section 14311 of the Welfare and Institutions Code is amended to read:

14311. **Prepaid health plans, the services they provide and the persons receiving such services shall not be subject to the limitations on services set forth in Section 14133 or 14133.1, or the provisions of subdivision (c), (d), and (e) of Section 14120, or the fifth paragraph of Section 14105.**

Nothing in this section or in Article 7 (commencing with Section 14490) of this chapter shall relieve the director of his responsibility to provide the benefits provided for in Section 14132. Where a contract between the department and a prepaid health plan does not require the prepaid health plan to provide a benefit to which a Medi-Cal recipient is otherwise entitled, the recipient shall be entitled to receive such benefit pursuant to Chapter 7 (commencing with Section 14000) of this part.

SEC. 5. Section 14312 of the Welfare and Institutions Code is amended to read:

14312. The director shall adopt all necessary rules and regulations to carry out the provisions of this chapter. In adopting such rules and regulations, the director shall be guided by the needs of eligible persons as well as prevailing practices in the delivery of health care on a prepaid basis. Except where otherwise required by federal law or by this part, the rules and regulations shall be consistent with the requirements of the Knox-Keene Health Care Service Plan Act of 1975.

SEC. 6. Section 14404 of the Welfare and Institutions Code is amended to read:

14404. In order to enable Medi-Cal beneficiaries to fully use the system of their choice, at the time of

determining the eligibility for Medi-Cal of persons who reside in an area served by a prepaid health plan and who are eligible to enroll in such a plan, the director shall make available to such persons information prepared by the department summarizing the benefits and restrictions to beneficiaries enrolled in prepaid health plans as opposed to the fee-for-service system. The department shall prescribe the format for providing the information required pursuant to this section.

SEC. 7. Section 14405 of the Welfare and Institutions Code is amended to read:

• 14405. The director shall make available such information as is necessary to enable Medi-Cal beneficiaries to exercise an informed choice in receiving benefits under this chapter. For this purpose each prepaid health plan shall provide marketing material to the director for distribution to all prospective enrollees in the plan's service area. Such marketing material shall include the following:

(a) A description of all services and benefits provided by the prepaid health plan.

(b) The location of facilities where benefits and services are provided.

(c) The hours and days when services are available at each of the facilities.

(d) The addresses where primary care physicians, dentists, optometrists, or psychologists provide health services to enrollees of the prepaid health plan.

(e) The names and addresses of each hospital which has agreed to provide health services to the enrollees.

(f) Names and addresses of each pharmacy providing pharmaceutical services to the enrollees.

(g) Transportation arrangements offered by the prepaid health plan.

(h) Any other information as the department may require.

SEC. 8. Section 14406 of the Welfare and Institutions Code is amended to read:

14406. (a) Within seven days after the effective date of enrollment, the prepaid health plan shall provide in

APPENDIX I

Technical Details of Data Collection,
Processing, and Analysis

(Not included: available from NTIS only)

APPENDIX J

Acceptability of Methods Survey

Appendix J

Acceptability of Methods Survey

In the design stages of the marketing/enrollment demonstrations, PHRED Project staff recognized that no matter how high the penetration percentage or how low the cost per choice, a viable alternative to door-to-door solicitation would be difficult to implement if it was unacceptable, for whatever reasons, to the principal participants--the HMOs, county, and and state government officials and consumers. Because of the differing perspectives of each group the Project decided to attempt to measure acceptability and included it among the criteria for evaluation of the various methods.

Two surveys were performed. The first was administered to county personnel in the welfare office demonstration sites, the second survey to HMO contractors who had participated in the demonstrations. Overall results of each are discussed below. The early intention was to also survey consumer groups however, on-going liaison with several major organizations indicated support for, and agreement with the replacement of solicitation by dual choice in the welfare office, and a final survey was not carried out.)

I. County Acceptability Survey

An acceptability survey was administered to county workers who participated, either directly or indirectly, in the PHRED Project demonstrations. The survey forms were completed by eligibility workers, supervisors and clerical staff. Due to the one year time span of the demonstrations and the high turnover of county eligibility workers, many of the participants were not available for comment and some of the employees who answered the survey had not been directly involved in the project.

The total number of respondents was 93. Orange County returned 27 survey forms; Contra Costa County, 26; Los Angeles County, 21; and Sacramento, 19. Alameda County provided separate statements.

The results identified some major differences among the counties but all shared one common concern: Eligibility workers do not want to give the dual-choice presentation as a part of their functional responsibilities. Two reasons were given: a lack of time and a desire to separate the dual choice from the eligibility determination process.

Overall, county employees offered about a one-third percentage of "no opinion" and a low percentage of "unacceptable" responses. Many of the workers answered only the questions which pertained directly to the county workers' involvement in the dual-choice process.

The survey questions and responses follow. Los Angeles County responses are included in the total sample but have also been displayed separately because of the preponderance of Health Maintenance Organizations and welfare recipients in that particular county. Contra Costa County responses are also displayed separately for some items because they often represent the other end of the continuum, reflecting the latter's

different experience in an area in which the county itself operates the HMO which has been offered as a Medi-Cal choice in the welfare offices for a number of years.

The complete instrument may be found at the end of this appendix (page _). For the convenience of the reader, each question/item is given below before the results are tabulated and discussed.

Survey Items and Results

1. Method Evaluation

	Time	Comprehension	Objective	Practical
PHRED Representative				
HMO Representative				
County Worker				
Film				
Brochure				

Definitions

Time--Did this method take a reasonable amount of client and EW time?

Comprehension--Did the clients seem to understand the dual choice process? Did the clients ask their EW to re-explain the dual choice?

Objective--Did this method appear unbiased in presenting the two kinds of Medi-Cal?

Practical--If this method is implemented, would it be practical in your office? (Please rate only the method of the presentation using a simple choice form, rather than the paperwork used by the Project.)

Scale

0 = unacceptable 1 = no opinion 2 = acceptable

Table 1a. METHODS
Responses--All Counties

	Time # %	Comprehension # %	Objective # %	Practical # %
PHRED Representative				
Unacceptable	14 = 15%	10 = 11%	9 = 10%	17 = 18%
No opinion	37 = 40%	45 = 48%	48 = 51%	45 = 49%
Acceptable	42 = 45%	38 = 41%	36 = 39%	31 = 33%
HMO Representative				
Unacceptable	12 = 13%	11 = 12%	20 = 21%	15 = 16%
No opinion	47 = 51%	51 = 55%	50 = 54%	50 = 54%
Acceptable	34 = 36%	31 = 33%	23 = 25%	38 = 30%
County Worker				
Unacceptable	47 = 51%	23 = 25%	18 = 19%	42 = 45%
No opinion	30 = 32%	45 = 48%	50 = 54%	35 = 38%
Acceptable	16 = 17%	25 = 27%	25 = 27%	16 = 17%
Film				
Unacceptable	5 = 5%	11 = 12%	6 = 6%	17 = 18%
No opinion	48 = 52%	59 = 63%	62 = 67%	53 = 57%
Acceptable	40 = 43%	23 = 25%	25 = 27%	23 = 25%
Brochure				
Unacceptable	5 = 5%	10 = 11%	7 = 8%	10 = 11%
No opinion	48 = 52%	55 = 59%	56 = 60%	47 = 50%
Acceptable	40 = 43%	28 = 30%	30 = 32%	36 = 39%

(N = 93)

The no opinion responses range between 32 percent and 67 percent. The HMO representative method, considered to be one of the most controversial, did not receive a high unacceptable response, overall. The county worker method received the most unacceptable responses. The main areas of concern were time and practicality.

Table 1b. METHODS
Responses--Los Angeles Only

	Time #	Time %	Comprehension #	Comprehension %	Objectives #	Objectives %	Practical #	Practical %
PHRED Representative								
Unacceptable	1	4%	0	0%	0	0%	0	0%
No opinion	10	48%	11	52%	12	57%	12	57%
Acceptable	10	48%	10	48%	9	43%	9	43%
HMO Representative								
Unacceptable	2	10%	0	0%	0	0%	2	10%
No opinion	11	52%	13	62%	15	71%	12	57%
Acceptable	8	38%	8	38%	6	26%	7	33%
County Worker								
Unacceptable	11	52%	5	24%	2	10%	8	38%
No opinion	3	14%	9	43%	12	57%	6	29%
Acceptable	7	33%	7	33%	7	33%	7	33%
Film								
Unacceptable	0	0%	1	4%	0	0%	1	4%
No opinion	7	33%	11	53%	13	62%	13	62%
Acceptable	14	67%	9	43%	8	38%	7	33%
Brochure								
Unacceptable	2	10%	2	10%	2	10%	0	0%
No opinion	12	57%	9	42%	12	57%	11	52%
Acceptable	7	33%	10	48%	7	33%	10	48%

(N = 21)

2. How would you rate the demonstration materials, using the definitions below and the following scale:

   0 = unacceptable 1 = no opinion 2 = acceptable

	Comprehensive	Informative	Objective	Interesting
Flip Chart				
Script (Presentation)				
Brochure				
Film				

Definitions

Comprehensive--Was it easy to understand?
Informative--Did it present useful information?
Objective--Was it unbiased in presenting the two kinds of Medi-Cal?
Interesting--Was it interesting to the clients?

Table 2a. MATERIALS
Responses--All Counties

	Comprehensive # %	Informative # %	Objective # %	Interesting # %
Flip Chart				
Unacceptable	14 = 15%	11 = 12%	11 = 12%	17 = 18%
No opinion	54 = 58%	59 = 63%	57 = 61%	62 = 67%
Acceptable	25 = 27%	23 = 25%	25 = 27%	14 = 15%
Script				
Unacceptable	2 = 2%	4 = 4%	6 = 6%	12 = 13%
No opinion	60 = 65%	64 = 69%	59 = 64%	67 = 72%
Acceptable	31 = 33%	25 = 27%	28 = 30%	14 = 15%
Brochure				
Unacceptable	9 = 10%	7 = 7%	7 = 7%	16 = 17%
No opinion	51 = 55%	52 = 56%	51 = 55%	58 = 62%
Acceptable	33 = 35%	34 = 37%	35 = 38%	19 = 21%
Film				
Unacceptable	8 = 9%	7 = 7%	8 = 9%	13 = 14%
No opinion	60 = 64%	60 = 65%	62 = 66%	68 = 73%
Acceptable	25 = 27%	26 = 28%	23 = 25%	12 = 13%

(N = 93)

The majority of the respondents offered no opinion regarding the materials. The highest number of unacceptable responses was to the question of "Were the materials interesting?" Although 13 - 17 percent of the respondents answered no, 15 - 21 percent answered yes. The brochure received the highest overall rating with one third of the respondents describing it as comprehensive, informative, and objective, if not interesting.

Table 2b. MATERIALS
Responses--Los Angeles Only

	Comprehensive		Informative		Objective		Interesting	
	#	%	#	%	#	%	#	%
Flip Chart								
Unacceptable	0	0%	1	5%	1	5%	2	10%
No opinion	17	81%	11	52%	9	43%	16	76%
Acceptable	4	19%	9	43%	11	52%	3	14%
Script								
Unacceptable	0	0%	0	0%	0	0%	2	10%
No opinion	13	62%	11	52%	7	33%	15	71%
Acceptable	8	38%	10	48%	15	67%	4	19%
Brochure								
Unacceptable	1	5%	1	5%	2	10%	3	14%
No opinion	9	43%	9	43%	7	33%	12	57%
Acceptable	11	52%	11	52%	12	57%	6	29%
Film								
Unacceptable	0	0%	0	0%	2	10%	2	10%
No opinion	10	48%	9	53%	9	43%	13	62%
Acceptable	11	52%	12	57%	10	48%	6	28%

(N = 21)

3. If any of the following methods are implemented, at what point in the eligibility process should it be presented? Indicate your opinion of each, using the following scale:

   0 = unacceptable* 1 = no opinion 2 = acceptable

	County Worker	HMO Rep	PHRED Rep	Film	Brochure
In Conjunction With Screening Interview (If Applicable)					
Immediately After EW Interview					
During EW Homecall (If Applicable)					
Other** (See Below)					

*Please explain "unacceptable" responses.

**A Medi-Cal presentation scheduled at a time other than the EW interview but prior to approval of the application. For example, presentations could be scheduled on a daily basis at 9:00, 11:00, 1:00, and 3:00 o'clock. (This method was not tested in the demonstrations.)

Table 3a. ORDER IN PROCESS
Responses--All Counties

	County Worker # %	HMO Rep # %	PHRED Rep # %	Film # %	Brochure # %
In Conjunction with Screening Interview					
Unacceptable	50=54%	27=29%	25=27%	25=27%	16=17%
No opinion	34=36%	50=54%	52=56%	51=55%	47=51%
Acceptable	9=10%	16=17%	16=17%	17=18%	30=32%
Immediately After EW Interview					
Unacceptable	44=47%	22=24%	17=18%	21=23%	18=19%
No opinion	31=33%	34=36%	41=44%	41=44%	38=41%
Acceptable	18=20%	37=40%	35=38%	31=33%	37=40%
During EW Home Call					
Unacceptable	42=45%	29=31%	30=32%	34=36%	31=33%
No opinion	40=43%	51=55%	49=53%	49=53%	45=49%
Acceptable	11=12%	13=14%	14=15%	10=11%	17=18%
Other					
Unacceptable	34=36%	12=13%	11=12%	11=12%	8= 9%
No opinion	48=52%	61=65%	59=63%	60=64%	62=66%
Acceptable	11=12%	20=22%	23=25%	22=24%	23=25%

(N = 93)

All methods, other than the county worker method, were found to be acceptable immediately after the eligibility worker interview by 38 - 40 percent of the respondents. The highest "unacceptable" response was 54 percent for the county worker method in conjunction with the screening interview.

Table 3b. ORDER IN PROCESS
Response--Los Angeles Only

	County Worker #	%	Film #	%	HMO Rep #	%	PHRED Rep #	%	Brochure #	%
In conjuction with screening interview										
Unacceptable	12	57%	4	19%	3	14%	2	10%	1	5%
No opinion	7	33%	15	71%	14	67%	13	62%	13	62%
Acceptable	2	10%	2	10%	4	19%	6	28%	7	33%
Immediately after EW interview										
Unacceptable	6	28%	3	14%	2	10%	0	0%	2	10%
No opinion	12	57%	11	52%	10	48%	9	43%	10	48%
Acceptable	3	14%	7	33%	0	42%	12	57%	9	42%
During EW Home Call										
Unacceptable	11	52%	6	28%	5	24%	5	24%	11	52%
No opinion	7	33%	11	52%	12	57%	11	52%	11	52%
Acceptable	3	14%	4	19%	4	19%	11	52%	6	29%
Other										
Unacceptable	10	48%	3	14%	2	10	3	14%	2	10%
No opinion	9	42%	13	62%	16	76%	14	67%	13	62%
Acceptable	2	10%	5	24%	3	14%	4	19%	6	28%

(N = 21)

4. If one of the methods is implemented, when would be the appropriate time to present it to the client? Indicate your opinion of each, using the following scale:

0 = unacceptable 1 = no opinion 2 = acceptable

	During Intake Process	During Redetermination Process	Other (Explain)
PHRED Representative			
HMO Representative			
County Worker			
Film			
Brochure			

Other: _____

_____

*Please explain "unacceptable" responses.

Table 4a. SETTING
Responses--All Counties

Method:	Intake # %	Redetermination # %	Other* # %
PHRED Representative			
Unacceptable	19 = 20%	15 = 16%	--
No Opinion	34 = 37%	49 = 53%	90 = 97%
Acceptable	40 = 43%	29 = 31%	3 = 3%
HMO Representative			
Unacceptable	25 = 27%	18 = 19%	--
No Opinion	31 = 33%	46 = 50%	90 = 97%
Acceptable	37 = 40%	29 = 31%	3 = 3%
County Worker			
Unacceptable	43 = 46%	36 = 39%	--
No Opinion	35 = 38%	47 = 50%	90 = 97%
Acceptable	15 = 16%	10 = 11%	3 = 3%
Film			
Unacceptable	22 = 24%	19 = 20%	--
No Opinion	43 = 46%	52 = 56%	90 = 97%
Acceptable	28 = 30%	22 = 24%	3 = 3%
Brochure			
Unacceptable	13 = 14%	14 = 15%	--
No Opinion	37 = 40%	50 = 54%	90 = 97%
Acceptable	43 = 46%	29 = 31%	3 = 3%

(N = 93)

* Other = Several respondents suggested that the client be referred to the Medi-Cal presentation by client request only.

The intake setting was generally more acceptable than the redetermination setting for all methods.

Table 4b. SETTING
Responses--Los Angeles Only

Method:	Intake #	Intake %	Redetermination #	Redetermination %	Other
PHRED Representative					
Unacceptable	1	4%	0	0%	
No opinion	9	43%	14	67%	21 = 100%
Acceptable	11	53%	7	33%	
HMO Representative					
Unacceptable	3	14%	2	10%	
No opinion	9	43%	13	62%	21 = 100%
Acceptable	9	43%	6	28%	
County Worker					
Unacceptable	8	38%	7	33%	
No opinion	8	38%	13	63%	21 = 100%
Acceptable	5	24%	1	4%	
Film					
Unacceptable	0	0%	0	0%	
No opinion	12	57%	15	71%	21 = 100%
Acceptable	9	43%	6	29%	
Brochure					
Unacceptable	1	4%	2	10%	
No opinion	10	48%	13	61%	21 = 100%
Acceptable	10	48%	6	29%	

(N = 21)

5. I learned new information about Medi-Cal from participating in the Project. _____

Rate statement 5 using the following scale:

All County Response

0 = unacceptable 1 = no opinion 2 = acceptable

Overall, 27 percent (25 respondents) of the county workers stated that they did not learn new information. Sixty-one percent (57 respondents) stated that they had no opinion, and twelve percent

(11 respondents) stated that they learned new information from participating in the Project.

Los Angeles Only

Unacceptable	3 = 10%
No opinion	10 = 33%
Acceptable	8 = 38%

6. I think the clients were given valuable information about the Medi-Cal Program. _____

All County Response

0 = unacceptable 1 = no opinion 2 = acceptable

Overall, 17 percent (16 respondents) of the county workers stated that they thought their clients did not learn new information. Fifty-six percent (52 respondents) stated that they had no opinion, and twenty-seven (25 respondents) thought that their clients had learned new information from participating in the project.

Los Angeles Only

Unacceptable	2 = 10%
No opinion	7 = 33%
Acceptable	12 = 57%

7. Whom do you think should be responsible for explaining the Medi-Cal program to clients? _____

Table 7a. WHO SHOULD INFORM THE CLIENT
Responses

	All Counties #	All Counties %	Contra Costa #	Contra Costa %	Los Angeles #	Los Angeles %
Opinion	81	87%	26	100%	21	100%
No Opinion	12	13%	0	0	0	0
Total	93	100%	26	100%	21	100%

Table 7b. BREAKDOWN OF OPINIONS ON RESPONSIBILITY QUESTION

	All Counties		Contra Costa		Los Angeles	
	#	%	#	%	#	%
Eligibility Worker	15	19%	3	13%	1	5%
Medi-Cal Worker	12	15%	3	10%	1	5%
HMO Representative	11	14%	10	42%	0	0
Brochure Only	9	11%	1	3%	1	5%
Special Medi-Cal Rep	10	12%	1	3%	0	0
PHRED (State) Rep	16	20%	6	23%	16	75%
County Worker (Not EW or County PHP Rep)	4	5%	0	0	0	0
Definitely Not an EW	1	1%	0	0	1	5%
EW Should Present "Stickers,"* HMO Reps should present HMOs	2	1%	2	6%	0	0
No One	1	0	0	0	1	5%
	81	100%	26	100%	21	100%

*Fee-for-service Medi-Cal cards are referred to as "stickers" because of their removable labels.

The majority of the respondents answered the above question. The responses varied with the highest number agreeing that it is the state's responsibility to inform the clients of their Medi-Cal choice. Although 19 percent thought it is the EW's responsibility, most added that it was also impractical in the current county setting. An additional total of 26 respondents (32 percent) suggested that a specialized county worker (Medi-Cal worker, special Medi-Cal representative or county worker) should inform the client.

Fourteen percent of all the respondents indicated that it is the responsibility of the HMO representative to present the dual choice. This figure represents 42 percent of the Contra Costa employees and 0 percent of the Los Angeles County employees. HMO representatives currently present the dual choice in Contra Costa where the HMO is operated by the county itself; whereas in Los Angeles, the county's experience with the marketing activities of the health plans has been limited to dealing with complaints and problems generated by door-to-door solicitation.

8. Which of the methods, if implemented, would least interfere with your present duties? _____

Table 8a. METHOD WITH LEAST INTERFERENCE
Breakdown of Responses

	All Counties		Contra Costa		Los Angeles	
	#	%	#	%	#	%
Opinion	71 =	76%	26 =	100%	14 =	67%
No Opinion	20 =	24%	0 =	0	7 =	33%
Total	93 =	100%	26 =	100%	21 =	100%

Table 8b. METHOD WITH LEAST INTERFERENCE
Responses With Opinions

	All Counties		Contra Costa		Los Angeles	
	#	%	#	%	#	%
Brochure	20 =	28%	4 =	15%	4 =	29%
Film	4 =	6%	0 =	0	3 =	21%
PHRED Rep	15 =	21%	2 =	8%	3 =	21%
HMO Rep	20 =	28%	18 =	69%	0 =	0
EW	0 =	0	0 =	0	0 =	0
Any method except EW	8 =	11%	2 =	8%	1 =	7%
All methods unreasonably interfere	4 =	6%	0	0	3 =	21%
	71 =	100%	26 =	100%	14 =	99%

The brochure and HMO representative method were the overall favorites. However, the HMO method represents a 69 percent rate for Contra Costa and 0 percent for Los Angeles. As in question 7, the Contra Costa employees are comparing the method currently utilized with something that they view as a "new way." The brochure method and the HMO Representative Method were chosen by 28 percent of the respondents to be the methods with the least interference. Los Angeles respondents expressed 29 percent preference for the brochure method and none for the HMO Representative Method. It is interesting to note that 11 percent of the respondents stated that 11 percent of the respondents stated that it does not matter which

method is used to present dual choice as long as it does not involve the EWs. Also, 6 percent of the respondents stated that all of the methods "unreasonably" would interfere with their present duties. The reason most often given was that, regardless of the method, the clients always ask their EWs for clarification, confirmation, and/or validation and the EWs do not have the time to incorporate this into their schedules.

9. Which of the methods, if implemented, would most interfere with your present duties? _____
Why? _____

Table 9a. METHOD WITH MOST INTERFERENCE
Responses

	All Counties	Contra Costa	Los Angeles
	# = %	# = %	# = %
Opinion	69 = 74%	26 = 100%	16 = 76%
No Opinion	24 = 26%	= 0	5 = 24%
Total	93 = 100%	26 = 100%	21 = 100%

Table 9b. MOST DISRUPTIVE METHOD
Responses With Opinions

	All Counties	Contra Costa	Los Angeles
	# = %	# = %	# = %
Brochure	1 = 1%	0 = 0	0 = 0
Film	5 = 7%	0 = 0	4 = 25%
PHRED Representative	6 = 9%	1 = 4%	1 = 6%
HMO Representative	0 = 0	0 = 0	0 = 0
EW	50 = 72%	24 = 92%	7 = 44%
All Methods	7 = 11%	1 = 4%	4 = 25%
	69 = 100%	26 = 100%	16 = 100%

The answer given most often was that EWs do not have time to present dual-choice information. The methods which require an "outsider", such as a state worker, create interference because the county staff has to explain their procedure and incorporate the outsider's schedule and procedure into their schedules. Thus, 72

percent of the employees who answered the above question stated that the Eligibility Worker Method would most interefere with their present duties. This figure represents 92 percent of the Contra Costa employees (with a 100 percent response rate) and 44 percent of the Los Angeles employees (with a 76 percent response rate). The brochure method (0 percent) and the HMO representative method (1 percent) are consistent with the answers given in question 8.

10. Which method would be the least acceptable to you? _____

Why? _____

Table 10a. METHOD LEAST ACCEPTABLE Responses

	All Counties # Percent	Contra Costa # Percent	Los Angeles # Percent
Opinion	64 = 69%	26 = 100%	11 = 53%
No Opinion	29 = 31%	= 0	10 = 47%
Total	93 = 100%	26 = 100%	21 = 100%

Table 10b. METHOD LEAST ACCEPTABLE Responses With Opinions

	All Counties # %	Contra Costa # %	Los Angeles # %
Brochure	2 = 3%	1 = 4%	1 = 9%
Film	3 = 5%	0 = 0%	0 = 0%
PHRED Representative	4 = 6%	0 = 0%	0 = 0%
HMO Representative	5 = 8%	0 = 0%	0 = 0%
EW	50 = 78%	25 = 96%	10 = 91%
	64 = 100%	26 = 100%	11 = 100%

The answer most often given was "EWs do not have the time to present the Medi-Cal information." Contra Costa (96 percent) and Los Angeles County (91 percent) agreed with the 78 percent overall total of employees indicating that the EW method would be the least acceptable method.

11. Which method would be most acceptable to you? _____
Why? _____

Table 11a. METHOD WITH MOST ACCEPTANCE
Responses

	All Counties		Contra Costa		Los Angeles	
	#	Percent	#	Percent	#	Percent
Opinion	65	= 70%	26	= 100%	15	= 70%
No Opinion	28	= 30%		= 0%	6	= 30%
Total	93	= 100%	26	= 100%	21	= 100%

Table 11b. METHOD WITH MOST ACCEPTANCE
Responses with opinions

	All Counties		Contra Costa		Los Angeles	
	#	%	#	%	#	%
Brochure	22	= 34%	4	= 14%	6	= 41%
Film	6	= 9%	1	= 3%	5	= 33%
PHRED Representative	13	= 20%	4	= 17%	2	= 13%
HMO Representative	17	= 26%	16	= 63%	0	= 0%
EW	2	= 3%	1	= 3%	2	= 13%*
Anything but EW	5	= 8%	0	= 0%	0	= 0%
	65	= 100%	26	= 100%	15	= 100%

*The respondents specified a "special" EW.

As noted in the previous question, the EW method received the lowest percentage of positive responses. The method most acceptable overall is the brochure method with 34 percent of the overall and 41 percent of the Los Angeles respondents choosing this method. The HMO representative method ranks second overall with 63 percent of all the Contra Costa respondents ranking it as the most acceptable method. Los Angeles County respondents disagreed, ranking it 0.

12. If the method you suggest in item 11 is implemented, would you recommend any procedural changes? No ___ Yes ___ What changes?

_____

_____

The preponderance of respondents provided no answer to this question. Of those who did respond, most misinterpreted the question, suggesting that the dual choice be placed either at intake or redetermination.

Now is your chance to give us your general comments on the dual-choice program and the PHRED Project.

Comments: _____

_____

_____

_____

Most respondents provided no comments. Of those who addressed the question, most felt that the PHRED Project had been an unwelcome intrusion upon their work setting.

II. Health Plan Acceptability Survey

The health plans which participated in the PHRED Project marketing/ enrollment demonstrations were asked to complete a survey to determine the acceptability of the methods to HMOs. Of the nine which had originally participated, two were no longer contracting with the State to provide services to Medi-Cal clients at the time of the survey. Four of the remaining seven plans responded.

In summary, the plans felt that each method had certain advantages and disadvantages although the use of a plan representative was favored, either alone or in conjunction with other methods. The survey instrument may be found on page _____; each question is listed below, followed by the plans' responses.

Questions and Responses

1. What were the advantages which you saw in each of the following enrollment methods?

   A. Mailing:

      Responses to the mailing method varied. One plan saw no discernible advantage to the mailing method employed by PHRED. Three plans noted that the mailing did provide a large number of clients who were already eligible to enroll in a plan with information about the plans. One of those plans further stated that this method at least shows the recipient that the Department of Health Services has a positive view of the HMO Program.

   B. Welfare Office Presentations:

      1. Brochure Only Method:

         Two plans responded that the Brochure Only Method was not useful, or at best, adequate. The only perceived advantage was that it provided information about HMOs to those clients who could and would read the materials.

      2. Film Method:

         The health plans universally agreed that the film method provided information about the HMO and fee-for-service delivery systems to clients. One plan added, however, that the film could not stand alone as a method. Someone would need to be present to respond to specific questions about the alternatives.

3. County Representative Method:

The county representative method was viewed as a useful way to bring more credibility to the HMO program as well the means to a universal choice-mailing situation. One plan expressed the opinion that this method was more personal (and, therefore, better) than the brochure or film methods.

4. State Representative Method:

The state representative method gathered a variety of responses from the four health plans. One felt that the method had no advantages. Another stated that, like the county worker method, the state representative method was more personal than the film or brochure methods. One plan stated that a neutral presentation was given to the client which allowed the choice to be made. Another stated that use of the state representative method showed that the Department of Health Services was concerned about the availability of health care delivery.

5. Plan Representative Method:

The plan representative method was perceived by the survey respondents to be the most advantageous. Reasons cited included the personal approach of a one-on-one encounter, the increase in credibility for the HMO program, and the belief that plan representatives understand the plan specifics better and more accurately than either a county worker or a state representative.

2. What were the disadvantages of each method?

A. Brochure Only Method:

Two major disadvantages to the Brochure Only Method were cited by the survey respondents:

1. Clients often cannot or will not read materials.

2. The brochure was not descriptive and detailed enough to compare and decide on an alternative without verbal assistance. One plan also felt that the brochure alone is not enough of a motivator to trigger a choice.

B. Film Method:

The film method did not present enough information and detail to allow an informed choice, according to the survey respondents. One plan stated that the film was not geared to motivating a choice for the HMO delivery system.

C. County Representative Method:

Two respondents felt that county workers were negatively biased against the HMO delivery system. One respondent stated that the county worker could not give as comprehensive a presentation as the plan representative could. Another plan felt that problems with county workers regarding HMO activities were controlled under the PHRED Project but could become evident in the future as county workers were reassigned or added.

D. State Representative Method:

Two plans stated that the state representative did not present information in as comprehensive a fashion as the plan representative. One plan felt that a disadvantage to the state representative method was that state employees had not been trained in marketing sales techniques. Another felt that the neutrality of the state representative afforded much less than a recommendation to try the HMO delivery system.

E. Plan Representative Method:

Two plans felt constricted by the research design. (Plan representatives were not allowed to proceed with a more comprehensive presentation than allowed for by the demonstrations.) One plan stated that a disadvantage was the inability of the plan representative to work on a pay-incentive basis. (Plans were not allowed to pay commissions for enrollments generated by their representatives during the welfare office demonstrations.) Another plan had no problems with this method.

3. If you had to pick one or a combination of these methods as a primary enrollment program, which would you choose and why?

Each survey respondent presented a different answer to this question.

A. Use the plan representative method with the film method.

B. Have a county representative provide an overall presentation and a plan representative provide more specific information.

C. Have a county representative show the film followed by a plan representative to provide more specific information.

D. Use a film produced by the plan in conjunction with the state and discussed by health plan representatives.

4. Which method(s) would you recommend not using and why?

One plan had no response to this question. One plan argued that the brochure and the film alone should not be used because they did not enable the recipient to ask questions. Another plan stated that the mailing and brochure methods should not be used because the materials are not read and response is low. Finally, one plan stated that county representatives are generally not interested, trained, or desirous of being involved in making a presentation involving choice to a recipient. The plan further stated that the county representatives' biases provide a strong negative base for presentation of alternatives to the traditional Medi-Cal systems.

5. Are there other methods which you would like to see the Department try?

Plans supplied a number of alternative marketing methods in response to this question.*

A. Plan representative could provide a comprehensive enrollment presentation in the welfare office followed by a state or county verification.

B. Assignment of recipients to HMOs.

C. Re-establish the two-service per month limitation on the fee-for-service delivery system.

*Additionally, one plan suggested that the Department of Health Services require a six-month lock-in for clients choosing an HMO.

6. Do you have any other comments on the PHRED marketing/enrollment demonstrations?

Comments provided by the survey respondents were as follows:

A. One plan had no comment.

B. One plan felt that the Department of Health Services should continue to explore alternative marketing strategies.

C. One plan felt that telephone verifications of new enrollments is too costly and time-consuming to justify the results obtained.

D. One plan felt that the HMOs should have had more input to development of the PHRED Project film.

(County) ACCEPTABILITY SURVEY

County Position: _____
County Office: _____
County: _____

Rate each method, using the definitions below and the following scale:

0 = unacceptable 1 = no opinion 2 = acceptable

1. Method Evaluation

	Time	Comprehension	Objective	Practical
PHRED Representative				
HMO Representative				
County Worker				
Film				
Brochure				

Definitions

Time--Did this method take a reasonable amount of client and EW time?

Comprehension--Did the clients seem to understand the dual choice process? Did the clients ask their EW to re-explain the dual choice?

Objective--Did this method appear unbiased in presenting the two kinds of Medi-Cal?

Practical--If this method is implemented, would it be practical in your office? (Please rate only the method of the presentation using a simple choice form, rather than the paperwork used by the Project.)

2. How would you rate the demonstration materials, using the definitions below and the following scale:

0 = unacceptable 1 = no opinion 2 = acceptable

	Comprehensive	Informative	Objective	Interesting
Flip Chart				
Script (Presentation)				
Brochure				
Film				

Definitions

Comprehensive--Was it easy to understand?

Informative--Did it present useful information?

Objective--Was it unbiased in presenting the two kinds of Medi-Cal?

Interesting--Was it interesting to the clients?

3. If any of the following methods are implemented, at what point in the eligibility process should it be presented? Indicate your opinion of each, using the following scale:

0 = unacceptable* 1 = no opinion 2 = acceptable

Methods:	County Worker	HMO Rep	PHRED Rep	Film	Brochure
In Conjunction With Screening Interview (If Applicable)					
Immediately After EW Interview					
During EW Homecall (If Applicable)					
Other** (See Below)					

**A Medi-Cal presentation scheduled at a time other than the EW interview but prior to approval of the application. For example, presentations could be scheduled on a daily basis at 9:00, 11:00, 1:00, and 3:00 o'clock.

*Please explain "unacceptable" responses.

4. If one of the methods is implemented, when would be the appropriate time to present it to the client? Indicate your opinion of each, using the following scale:

0 = unacceptable* 1 = no opinion 2 = acceptable

	During Intake Process	During Redetermination Process	Other (Explain)
PHRED Representative			
HMO Representative			
County Worker			
Film			
Brochure			

*Please explain "unacceptable" responses.

Other: _____

Rate statements 5 and 6 below, using the following scale:

0 = unacceptable* 1 = no opinion 2 = acceptable

5. I learned new information about Medi-Cal from participating in the Project. _____

6. I think the clients were given valuable information about the Medi-Cal Program. _____

*Please explain "unacceptable" responses.

_____

_____

_____

******** ********

7. Whom do you think should be responsible for explaining the Medi-Cal program to clients? _____

_____

_____

8. Which of the methods, if implemented, would least interfere with your present duties? _____

9. Which of the methods, if implemented, would most interfere with your present duties? _____
Why? _____

_____

10. Which method would be the least acceptable to you? _____
Why? _____

_____

11. Which method would be most acceptable to you? _____
Why? _____

_____

12. If the method you suggest in item 11 is implemented, would you recommend any procedural changes? No _____ Yes _____ What changes? _____

_____

_____

Now is your chance to give us your general comments on the dual choice program and the PHRED Project.

Comments: _____

1. What were the advantages which you saw in each of the following enrollment methods?

   A. Mailing _____

   _____

   _____

   B. Welfare Office Presentations:

      1. Brochure Only Method _____

      _____

      _____

      _____

      2. Film Method _____

      _____

      _____

      _____

      3. County Representative Method _____

      _____

      _____

      _____

      4. State Representative Method _____

      _____

      _____

      _____

      5. Plan Representative Method _____

      _____

      _____

      _____

2. What were the disadvantages of each method?

A. Brochure Only Method _____

B. Film Method _____

C. County Representative Method _____

D. State Representative Method _____

E. Plan Representative Method _____

3. If you had to pick one or a combination of these methods as a primary enrollment program, which would you choose and why?

4. Which method(s) would recommend not using and why?

5. Are there other methods which you would like to see the Department try?

6. Do you have any other comments on the PHRED marketing/enrollment demonstrations?

APPENDIX K

Plan Agreement to Participate, Performance Specifications

(Examples only; full set available from NTIS)

DEPARTMENT OF HEALTH SERVICES
[illegible] STREET 455 Capitol Mall, Room 250
RAMENTO, CA 95814
16) 322-4616

10 May 1979

Elizabeth Lamkin
CompreCare
3850 Wilshire Boulevard
Los Angeles, CA 90010

Dear Ms. Lamkin:

This letter confirms agreements reached with your plan regarding the participation of CompreCare in the PHRED Project Membership Studies demonstrations. Based on those discussions we respectively agree to the following provisions:

General Provisions

A. Nothing in this agreement requires either party to reimburse the other for performing under the terms of the agreement and reimbursement shall not take place.

B. Performance under the terms of this agreement does not relieve CompreCare of its total responsibility for the conduct of all marketing activities in accordance with Title 22, CAC Section 53400 and the terms of its contract with the Department of Health Services contract #78-62993, and Section 1361 of the Health and Safety Code.

C. This agreement is entered into to comply with the provisions of Welfare and Institutions Code Section 14411(a)(1) and (3).

CompreCare agrees to perform the following:

A. Report required presentation results and cost data in formats specified by the Department and attached to this agreement, and retain such data for no less than one year following the termination of this agreement.

B. Assign qualified marketing representative(s) as defined in Section 53402, Title 22, California Administrative Code and Article VIII(I) of the contract with the Department of Health Services to participate for at least a 10-week period as specified by the Department in the demonstration project at the designated demonstration site. During participation in the demonstration, reimbursement for such representative(s) shall not be based on numbers of eligible Medi-Cal beneficiaries enrolled through the demonstration.

C. Adhere strictly to the research design of the demonstration as specified by the Department.

D. Provide supervision for CompreCare representative(s) participating in demonstrations, i.e., ensure punctuality, provide replacement if representative(s) become unavailable, etc.

E. Release CompreCare representative(s) and their supervisor(s) for training as required by the Department to meet the terms of this agreement.

F. Use written materials developed by the Department for the demonstrations at the demonstration site.

The California Department of Health Services agrees to perform the following:

A. Describe all data required and provide all reporting formats, timetables, forms and procedures.

B. Develop and provide a time schedule for each demonstration within the Project prior to the beginning date of the Project.

C. Provide training to CompreCare representative(s) participating in the demonstrations.

D. Obtain required space in demonstration sites for said CompreCare representative(s).

E. Monitor the performance of the demonstration.

F. Provide technical assistance to CompreCare during the term of the project to ensure adherence to research procedures.

G. Provide referrals from mailing and welfare office demonstrations for plan follow-up.

H. Provide CompreCare with a final report on the outcome of the project.

I have also attached a schedule and a listing of the ZIP Codes served by the demonstration site welfare office. Please sign on the line below and return this original copy to me. You may keep the second copy for your records.

Sincerely,

John M Lamkin for

Elizabeth W. Owen
Research Specialist
Membership Studies
PHRED Project

_____
CompreCare

X-2

_____
(Date)

Direct Costs	Total # Hrs.	$ Cost
A. Direct Labor (Salary and Commission)		
1. Enroller #1		
Enroller #2		
Enroller #3		
2. Clerical		$
3. Verification Staff		$
4. Supervisor		$
5. Marketing Manager		$
B. Payroll Additives (% of DL)		$
C. Mileage		$
D. Other Direct Costs (specify)		
		$

Indirect Costs (give total expense for period)

A. materials (printed)	$
B. Advertising Costs	$
C. Tapes for Verifications	$
D. Other Supplies	$
E. Telephone	$
F. Equipment	$
G. Space (rent	$
H. Utilities	$
I. Depreciation	$
J. Other (specify)	
	$

State of California–Health and Welfare Agency

PRESENTATION RESULTS REPORT

Department of Health Ser

Name of Rep:

Name of Plan:

Method:

Date:

(1) a. Street b. City	(2) Street Number:	(3) Apt. Number	(4) Person Home? Yes/No	(5) a. Name of Person Contacted b. Medi-Cal Number	(6) Eligible for PHP Yes/No	(7) Name of PHP If Enrolled	(8) Presentation Made Yes/No	(9) Refusal of Presentation Yes/No/N.A.	(10) Number of Enrollments	(11) Number of Persons In Family	(12) Time Started (Ex: 12:15 P.M.)	(13) Time Ended (Ex: 12:30 P.M.)	(14) Time in Transit (Ex: 010 Min.)	(15) a. Phone Number (If Available b. Notes (Explain Nos. in 8 & 9 Discrepancy in 10 & 1
a.				a.										a.
b.				b.										b.
a.				a.										a.
b.				b.										b.
a.				a.										a.
b.				b.										b.
a.				a.										a.
b.				b.										b.
a.				a.										a.
b.				b.										b.
a.				a.										a.
b.				b.										b.

K-4

State of California—Health and Welfare Agency

Department of Health Services

REFERRAL INFORMATION FORM (RIF)

Appendix D: Data Collection Forms
Item 11
Referral Information Form

1. Referral Number: ☐☐☐☐☐☐☐

2. Referral's Name: (Last, First, Middle)

3. Referral's Medi-Cal Number: ☐☐☐☐☐☐☐☐☐☐

4A. Referral's Address (House Number, Street or Road)

(City) (County)

4B. Zip: ☐☐☐☐☐

5. Referral's Phone Number: ☐☐☐ ☐☐☐ ☐☐☐☐

6. Date Sent to Plan: ☐☐ ☐☐ ☐☐

7. Date RIF returned to PHRED: ☐☐ ☐☐ ☐☐

Name of Plan _____

To Plan: The above person has indicated that he/she wishes to enroll after receiving a presentation and/or information in the local Social Services Office.

8. Please contact this person within: ☐☐ (Days)

9. And return this form to PHRED by: ☐☐ ☐☐ ☐☐ Month Day Year

DESCRIBE THE FIRST CONTACT:

10. Date: ☐☐☐☐☐☐ (Month, Day, Year)

11. Method of Contact:
1) ☐ Phone 2) ☐ Mail
3) ☐ Home 4) ☐ Walk-In

12. Results of first contact:
1) ☐ Verified Enrollee 2) ☐ Enrolled Other Plan
3) ☐ No Contact 4) ☐ Decision Pending
5) ☐ Stay on Regular Medi-Cal 6) ☐ Other: _____

13. How many persons enrolled? ☐☐ (Enter number)

14. Does this represent the referral's total family?
1) ☐ Yes 2) ☐ No

15. How many not enrolled? ☐☐

16. Explain nonenrolling family members (if any) _____

17. How many attempts were made before the individual was contacted? ☐☐ (Enter number)

IF MORE THAN ONE CONTACT, DESCRIBE THE LAST:

18. Date: ☐☐☐☐☐☐ (Month, Day, Year)

19. Method of Contact:
1) ☐ Phone 2) ☐ Mail
3) ☐ Home 4) ☐ Walk-In

20. Results of Last Contact:
1) ☐ Verified Enrollee 2) ☐ Enrolled Other Plan
3) ☐ No Contact 4) ☐ Decision Pending
5) ☐ Stay on Regular Medi-Cal 6) ☐ Other: _____

K-5

ZIP Codes Served by the
Florence District Office

90001

90002

90003

Marketing HMOs to Medicaid Beneficiaries

Evaluation of Alternative Approaches

October 1981

The Complete Appendices

APPENDIX B

Medicaid HMO Marketing Practices
in Other States

In August 1979, a preliminary survey of other states was conducted by telephone to determine whether there was evidence of a trend toward more interest in Health Maintenance Organizations (HMOs), and especially if there were more interest among the Medicaid directors in establishing contracts with HMOs to provide prepaid health care to Medicaid beneficiaries. The survey concentrated on marketing laws and allowed practices.

A relative lack of understanding of the concept of HMOs was apparent. Some staff members of the Medicaid Medical Assistance Units in nearly every region were completely unaware of the existence of such organizations in their state. After providing a brief description of an HMO, there was sometimes an indication of knowledge of the existence of one or more in the state, but there was more often an indication that the state had not undertaken to establish contracts with them.

This lack of understanding and general unfamiliarity with the concept had noticeably changed when the survey was repeated one year later. Some of the states which formerly had had no operating HMOs (even if for "private patients" only), have since had some experience with attempts (not all successful) to establish HMOs. A few states had even begun to negotiate capitation rates in preparation for a contract. In no state was there evidence of restrictive legislation which would hinder the development of HMOs, either for employee groups or for Medicaid recipients.

The August 1980 survey showed that there were 15 states and the District of Columbia with HMO contracts and four others which had begun the process to establish them. Some of the states were moving more rapidly than others and projected completion of negotiations within a few months. Other states were planning on more distant completion dates: two in 1981, and one in fiscal year 1982-83.

Several combinations of marketing methods were being proposed, tried, adapted, and accepted or rejected. Perhaps because of the unsavory history of door-to-door marketing of health plans, most of the states with HMO contracts do not permit this form of marketing: seven forbid it and four others do not use it, while five allow it. (However, of the five states which allow it, only one takes the precaution of licensing the enrollers.)

Eleven of the states have adopted a program of state-controlled mailings of HMO information to all eligible persons (usually by means of computer-generated lists by ZIP code). There were mixed feelings about the success of this method. The issue of confidentiality, and the restrictions on the use of names and addresses by HMO representatives appeared to be better understood than in the previous year but it

remained a problem. A few states have allowed the release (by the counties' social services offices) of the names of newly eligible persons. In most of the states (12), a program to educate the new Medicaid beneficiaries about the "dual choice" method of delivery of health care has been undertaken by state and/or county workers in the social services offices as part of the eligibility process. There have been varying degrees of success with this method.

From the second survey, a general increase in the awareness of HMO activity, of understanding the benefits of establishing contracts with HMOs, and of the need for caution in doing so, was apparent among the staff at the Medicaid agencies. More states were establishing contracts and more were planning to do so. There were a few states where no HMO activity was reported; they were mostly rural. The more populous, heavily urban states appear to have much more HMO activity. The idea of the state serving as a liaison between the Medicaid recipient and the HMO appeared to be gaining acceptance across the country.

Medicaid Marketing Practices by States
1980

State	Number of Contracts with HMOs	Total 1979 Enrollment[a]	Door-to-Door Solicitation Allowed?	Are Mailings Done?	Welfare Office Choice
California	12	97,750[b]	Yes, on waiver basis only	Yes	enrolled
Colorado	2	1,002[b]	Yes, but not practiced	Yes	referred
District of Columbia	1	735	Yes, but not practiced	No	referred
Florida	10/80 planned				
Georgia	planned		No	?	referred
Hawaii	1	2,806	not practiced, not prohibited	No, use to	rec in office
Illinois	1	1,195	No	Yes	No
Maryland	7	9,175[b]	Yes	Yes	No
Massachusetts	4	3,425[b]	Yes	Yes	referred & enrolled
Michigan	5	53,854	No	Yes	referred
Minnesota	2	301	not practiced, not prohibited	Yes	referred & enrolled
New Hampshire	FY 82-83 planned				
New Jersey	1/81 planned		No	Yes	rec in office
New York	4	44,252[b]	No	Yes	referred & enrolled
North Carolina	1981 planned				
Ohio	1, plus 1 in 10/80	2,505	not practiced, not prohibited	Yes	referred
Oregon	1	11,554[c]	No	Yes	referred
Pennsylvania	1[d]	1,056	No	Yes	rec in office
Rhode Island	1	135	Yes	No	referred
Utah	1	4,470	Yes[e]	No	referred, rec-office
Washington	3	4,261[b]	No	Yes	referred rec-office
Wisconsin	2, plus 1 planned	778	No	No	referred & enrolled
Total		246,268			

a Membership as of 6/30/79.
b 1979 membership in fewer plans than contracted with in 1980.
c 1979 membership in one plan more than contracted with in 1980.
d At-risk contract, not a PHP.
e Names of eligibles (but no addresses) are provided to the plan.

Selected Data

48 states contacted 1980 (California, Guam, West Virginia not contacted)
4 more states to establish contracts with one - two years
15 states have contracts with the State to provide health care to Medicaid beneficiaries

MARKETING (of those responding)*

	Allowed	Not Allowed
Door-to-door marketing	5	11
	Yes	No
State licenses/examines/regulates enrollers	1	10
Mailing method	10	4
State controlled	9	1
Dual choice in Social Services Office	12	3
Enrollment at intake	5	5
HMO representative in office	2	
Refer to HMO for enrollment	11	
Plans' access to names of eligible persons		8
Follow-up only	2	
County gives names (only) of newly eligible persons	3	

DISENROLLMENT

State handles	0	
County handles	3	5
Plan handles	7	1
Automatic on request	6	2
Requires state approval	1	5

*Not all respondents answered all questions; some states were still formulating policy.

What other states are doing about Medicaid marketing

(Data from PHRED survey (telephone) of all state and territorial Medicaid agencies, August 1980.)

Fifteen states and the District of Columbia currently report contracts with HMOs for Medicaid.

Of these, nine allow door-to-door solicitation; however, in four states and the District of Columbia, it is not currently used. The other seven states specifically prohibit solicitation, although some have allowed it in the past. Five additional states do not have current contracts, but are developing them at the present time. At least three have decided to prohibit door-to-door solicitation.

Many states assist plans by sending marketing mailings (12); dual choice is offered in the welfare offices in 15 states, with four states reporting an HMO representative in at least some of the offices and the others split between workers enrolling directly and referring to plans for follow-up. In one state, names of eligibles (but not addresses!) are given to the HMO for leads.

A variety of mixtures of these methods are reported by the states, but no additional methods are reported.

Six states use more than one method within the state.

APPENDIX B

Informational Materials Used in Demonstrations

(Examples only; full set available from NTIS)

What's the difference

BETWEEN A MEDI-CAL CARD AND A MEDI-CAL HEALTH MAINTENANCE ORGANIZATION (HMO-PHP)?

¿Cuál es la diferencia

ENTRE UNA TARJETA DE MEDI-CAL Y UN PLAN DE MEDI-CAL (PHP-HMO)?

Please read this information carefully.

You will make your Medi-Cal choice when you come for your interview.

Choice Brochure - All Offices

Medi-Cal is the State's program for people who need help in paying for health care. If you get a county AFDC check or a gold Social Security check, you have a choice to make about your health benefits. You can choose either the monthly Medi-Cal sticker card program, where you locate your own doctor whenever you need one, or a Medi-Cal prepaid plan, where you get all your services from a single health plan each time you need care. These health plans are now called health maintenance organizations, or HMOs, and they have to meet requirements of both the Federal and State governments.

Although HMOs often provide extra services, either form of Medi-Cal can give you the health care that you and your family need.

Dos Clases de Medi-Cal

Medi-Cal es un programa del Estado para personas que necesitan ayuda económica para pagar servicios médicos para el cuidado de la salud. Si recibe un cheque del condado AFDC (Ayuda para Familias con Niños Dependientes) o un cheque dorado del Seguro Social, usted puede decidir acerca de sus beneficios médicos para el cuidado de su salud.

Usted puede escoger, ya sea el programa regular de Medi-Cal, recibiendo mensualmente una tarjeta de identificación que puede usar con el médico privado que usted escoja cuando lo necesite, o un plan prepagado de Medi-Cal, en donde recibe todos los servicios médicos necesarios dentro de un solo plan de salud, cada vez que necesite de estos servicios. Estos planes de salud se llaman ahora Organizaciones para el Mantenimiento de la Salud o Health Maintenance Organizations (HMOs), tienen que satisfacer los requerimientos de los dos niveles Federal y del Estado.

Aún cuando HMOs frecuentemente proveén servicios extra, cualquiera de estos dos programas de Medi-Cal puede darle los servicios para el cuidado de la salud que usted y su familia necesiten.

Advantages and Disadvantages

There are advantages and disadvantages to both kinds of Medi-Cal. You will want to consider them carefully before you decide which kind is best for you and your family.

Included with this brochure is specific information about the HMOs that you may join in your area, including a list of the extra services they provide. As you read the information about the HMOs, here are some things to consider before you decide which kind of Medi-Cal you want:

1. • When you become a member of an HMO, you have to use the HMO's doctors and other services (except if you can't get there in an emergency). • If you have monthly Medi-Cal stickers, you can use any doctor you choose — as long as he or she will take Medi-Cal patients.
2. • When you become a member of an HMO, you sign a contract (enroll) and you have a guaranteed right to medical care. • When you have Medi-Cal stickers, services can be guaranteed available *only* at your county hospital or other county facilities.
3. • In an HMO, there is a grievance system that is set up to try to solve any problems members have with their health plan's services. • If you have a problem with a doctor or other provider under the regular Medi-Cal system, it is up to you to discuss and settle it with the doctor or provider — or to find another to take care of you.
4. • When you become a member of an HMO, you remain a member as long as you continue to receive your AFDC or gold check. If, for some reason, you become unhappy with the HMO, it is possible for you to disenroll. Getting out of the health plan usually takes approximately 60 days.

Ventajas y Desventajas

Los dos programas de Medi-Cal, con etiquetas y prepagado, tienen sus ventajas y desventajas. Usted debe de considerarlos cuidadosamente antes de decidir cuál es el mejor programa para usted y su familia.

Incluida con este folleto es la información específica acerca de los HMOs en su área, con una lista de los servicios extra que provéen a los beneficiarios de Medi-Cal. Cuando lea la información acerca de HMOs, éstas son algunas cosas que debe de considerar antes de decidir que forma de Medi-Cal desea escoger:

1. • Cuando se subscribe a un HMO tiene que hacer uso de sus médicos y demás servicios (excepto en caso de emergencia cuando la facilidad no sea accesible a Ud.). • Si tiene Medi-Cal con etiquetas puede usar el médico de su preferencia, siempre y cuando el o ella acepte pacientes con Medi-Cal.
2. • Cuando se subscribe a un HMO, es como si firmara un contrato que le garantiza sus derechos a recibir cuidados para la salud. • Cuando tiene Medi-Cal con etiquetas, servicios médicos pueden ser garantizados a su disposición *solamente* en el hospital y otras facilidades de su condado.
3. • En un HMO hay un sistema de quejas que sirve para resolver cualquier problema que un subscriptor pueda tener con los servicios del plan de salud al que pertenece. • Si tiene un problema con el médico u otro proveedor bajo el sistema de Medi-Cal con etiquetas, depende de usted el discutirlo y resolverlo con el médico o proveedor, o encontrar a otro que se haga cargo de usted.
4. • Cuando se subscribe a un HMO, usted sigue siendo miembro por tanto tiempo como continúe recibiendo su cheque AFDC o un cheque dorado. Sin embargo, si por alguna razón usted ya no esta satisfecho con HMO, puede desenrolarse y dejar el plan de salud, un proceso que se lleva aproximadamente 60 días. • Con Medi-Cal con etiquetas, si

• With a Medi-Cal sticker card. If you become dissatisfied with your doctor, you can leave him or her and try to find another who will accept Medi-Cal patients.

5. • When you join an HMO, the HMO will send you a booklet that will tell you where its doctors, pharmacies, and other services are located, what their normal hours are, how to make an appointment for the kind of service you need, and what to do in an emergency. This information can be especially important to you. • There is no similar information package available for regular Medi-Cal, but it is important for you to ask your doctor in advance what to do if your child suddenly runs a fever in the middle of the night.

How to Choose

As long as you continue to receive your AFDC or gold check, you will not have to pay anything for your Medi-Cal benefits — either way. But you should still choose carefully.

For example, if you already have a family doctor who knows you and any health problems you may have, you are probably wise to stay with that doctor if he or she accepts Medi-Cal patients. But, if you do not have a family doctor, or if you can't find a doctor who will accept Medi-Cal patients, you may be better off joining an HMO — so that you will not have to try to find a doctor when you or your child become sick.

In making your choice, be sure to consider your whole family. For example, the State requires each HMO to give children who are plan members a full health examination to detect problems *before* they become serious. (This program is called Child Health Disability Prevention — CHDP.) You can get these exams for your children with a regular Medi-Cal card, but you must find a doctor who is willing to provide the service.

usted no está satisfecho con su médico puede dejarlo y encontrar otro quien acepte pacientes de Medi-Cal regular.

5. • Cuando usted se enrola a HMO, esta organización le enviará un libreto que le informará de sus médicos, farmacias, y demás servicios; también le informará a dónde están localizados, cuáles son las horas normales de servicio, cómo hacer una cita y que debe de hacer en un caso de emergencia. Esta información es de mucha importancia para usted. • No hay información similar de Medi-Cal con etiquetas, pero es importante que usted pregunta a su médico antes de que debe de hacer si su niño se le enferma de repente a la media noche.

Como Escoger

Por el tiempo en que continue recibiendo su cheque de AFDC o un cheque dorado, usted no tendra que pagar nada por los beneficios de Medi-Cal en cualquiera de sus dos formas. Pero aun así, debe de escoger con mucho cuidado.

Por ejemplo, si usted tiene un médico para toda la familia a quien ven con regularidad y sabe qué problemas de salud tienen, sería más prudente quedarse con el mismo médico, si es que acepta pacientes con las etiquetas de Medi-Cal. Pero si no lo tiene o no puede encontrar un médico que acepta pacientes con etiquetas de Medi-Cal, sería mejor subscribirse a un HMO y evitar el problema de encontrar a última hora un médico que lo atienda cuando usted o su niño se enferman de repente.

Cuando escoja, asegúrese que toma en consideración la familia entera. Por ejemplo, el Estado requiere de cada HMO que de a los niños (hasta a edad de 21 años) miembros del plan, un completo exámen de salud de acuerdo con el programa de Prevención contra la Incapacidad en la Salud del Niño (Child Health Disability Prevention), para descubrir problemas de salud *antes* de que se conviertan en problemas serios. Usted puede pedir estos servicios de un proveedor de Medi-Cal regular. El Estado no puede requerir de los médicos privados que lleven a cabo estos exámenes, pero sí pagará por ellos.

What you Can Get From Medi-Cal

These are the basic services that both forms of Medi-Cal provide for you:

- Visits to doctor's offices.
- Hospital and nursing home care when ordered by your doctor.
- Special checkups for children under age 21 and treatment if needed.
- Laboratory and X-ray services.
- Mental health services.
- Dental care.
- Chiropractic services.
- Medications.
- Eyeglasses, hearing aids, medical supplies, and medical equipment when ordered by your doctor.

Lo Que Puede Obtener de Medi-Cal

Estos son los servicios básicos que Medi-Cal, en sus dos formas, provée para usted:

- Visitas a la oficina del médico.
- Hospital y casa de convalecencia para enfermos cuando el médico lo ordene.
- Exámenes para niños hasta la edad de 21 años y tratamiento si es necesario.
- Servicios de laboratorio y rayos X.
- Servicios para la salud mental.
- Servicios dentales.
- Servicios quiroprácticos.
- Medicinas.
- Lentes ó anteojos, aparatos para oir, suplementos y equipo médico cuando el médico lo ordene.

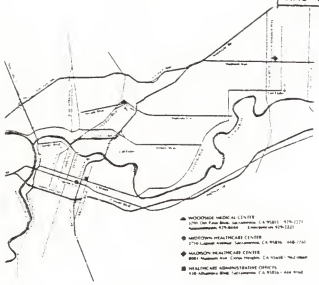
(DHS 5/79)

Usted tendrá que hacer su elección de Medi-Cal cuando venga a su entrevista.

Por favor lea esta información cuidadosamente.

California State Department of Health Services
455 Capitol Mall, Suite 250
Sacramento, Calif. 95814

Appendix B
HMO Brochure - Health Care



Healthcare Service Area Map

Area de Servicio de "Healthcare"

California State Department of Health Services
455 Capitol Mall, Suite 250
Sacramento, Calif. 95814

For further information, call
Healthcare 444-9160

GROUP HEALTH SERVICE PLAN

HEALTHCARE

444-9160

Group Health Service Plan is a nonprofit, prepaid group practice medical and hospital care plan for persons living in Sacramento, Yolo, Placer, and El Dorado counties within a 20-mile radius of any of the three Healthcare health care centers.

Healthcare is a direct-care health service system, providing continuing care for the entire family, as well as treatment for major illness and accidents, in its health centers, in the hospital and, on occasion, in the home. Healthcare encourages the use of its preventive, diagnostic, therapeutic, and rehabilitative services for health maintenance, early disease detection, and prompt medical treatment.

Grupo Del Plan de Servicios Para la Salud "Healthcare"

El Grupo del Plan de Servicios para la Salud ("Healthcare") no es lucrativo. Es un plan de salud prepagado de servicios médicos y de hospital para las personas residentes en los condados de Sacramento, Yolo, Placer y El Dorado, dentro de veinte millas a la redonda de cualquiera de los tres centros "Healthcare."

"Healthcare" es un sistema de servicios para la salud que provee cuidados directos y continuos para la familia entera, así como tratamiento de enfermedades graves y accidentes, en sus centros de salud, en el hospital y ocasionalmente en su hogar. El plan anima el uso de sus servicios preventivos, diagnósticos, terapéuticos y de rehabilitación, para el mantenimiento de la salud, temprana detección de enfermedades, y su tratamiento médico.

Services Available	Service Location Localidades de Servicios	Servicios Disponibles
Primary care, obstetrics and gynecology, pharmacy, physical therapy, laboratory and X-ray services. Specialist care, vision care, mental health services and home health services on referral. Special programs: Weight and smoking control, family planning and diet counseling.	Woodside Medical Center 3201 Del Paso Boulevard Sacramento, CA 95815 (916) 929-2221 Service Hours: 9:00 a.m.-5:00 p.m. (Mon.-Fri.) 9:00 a.m.-4:30 p.m. (Saturday) Horas de Servicio: 9:00 a.m.-5:00 p.m. (lunes a viernes) 9:00 a.m.-4:30 p.m. (sabados)	Cuidados primarios, obstetricia/ginecologia, farmacia, terapia fisica, laboratorio, y servicios de rayos X. Especialistas: cuidado de los ojos, salud mental y servicios para la salud en su hogar, si el médico lo refiere. Programas especiales: control de peso y para no fumar, planeamiento de familia, consejeros para la dieta.
Primary care and pharmacy. Specialist care, vision care, mental health services and home health services on referral. Other services available at Woodside Medical Center. Special Programs: Weight and smoking control, family planning and diet counseling.	Midtown Healthcare Center 2710 Capitol Avenue Sacramento, CA 95816 (916) 448-2261 Service Hours: 8:00 a.m.-4:30 p.m. (M-T-W & F) 9:00 a.m.-4:30 p.m. (Thursday) Horas de Servicio: 8:00 a.m.-4:30 p.m. (lunes a miercoles y viernes) 9:00 a.m.-4:30 p.m. (jueves)	Cuidados primarios y farmacia. Especialistas, cuidado de los ojos, salud mental y servicios para la salud en su hogar, si el médico lo refiere. Otros servicios disponibles en el Centro Médico Woodside. Programas especiales: control de peso y para no fumar, planeamiento de familia, consejeros para la dieta.
Primary care, pharmacy, laboratory and X-ray services. Specialist care, vision care, mental health services and home health services on referral. Other services available at Woodside Medical Center. Special Programs: Weight and smoking control, family planning and diet counseling.	Madison Healthcare Center 8001 Madison Avenue Citrus Heights, CA 95610 (916) 962-0660 Service Hours: 9:00 a.m.-5:00 p.m. (Mon.-Fri.) Horas de Servicio: 9:00 a.m.-5:00 p.m. (lunes a viernes)	Cuidados primarios, farmacia, laboratorio, y servicios de rayos X. Especialistas, cuidado de los ojos, salud mental y servicios para la salud en su hogar, si el médico lo refiere. Otros servicios disponibles en el Centro Médico Woodside. Programas especiales: control de peso y para no fumar, planeamiento de familia, consejeros para la dieta.
Major or minor surgery, coronary and intensive care, maternal and newborn care, 24-hour emergency service.	Hospitals in the Sacramento area, as designated by the attending Healthcare physician. Hospitales en la area de Sacramento, son designados por el medico que lo atiende.	Cirugía mayor y menor, cuidados maternos (servicios de maternidad) y para el recien nacido, servicios de emergencia 24 horas al día.

24-Hour Emergency Care

(916) 929-2221

For more information, call Healthcare at 444-9160 or the Department of Health Services at 1-800-952-5528 (no charge to you).

Servicio de Emergencia 24-Horas al Dia

(916) 929-2221

Para más información, favor de llamar al plan de salud al teléfono número 444-9160 o al Departamento de Servicios de Salud al numero 1-800-952-5528 (llamada gratuita).

Appendix B
HMO Brochure - CMGHP

California Medical Grou Health Plan, Inc. (CMGHP)

CMGHP, Inc. is a Federally-qualified Heal Maintenance Organization (HMO) current providing medical care for 114,000 membe in Southern California. Of these membe 59,000 are covered through private a governmental employer group health bene programs and 55,000 are Medi-Cal recipien covered through a contract with the Sta Department of Health Services which h been in effect for more than six yea CMGHP, INC. currently has the largest Me Cal HMO membership in California.

Grupo Médico Californi Plan de Salud, Inc.

El Grupo Médico California Plan de Sal Inc., es una Organización para el Mante miento de la Salud cualificada Federalme (HMO). En la actualidad, proveé cuidad médicos para 114,000 miembros de grup privados u del gobierno y 55,000 más quien son recipientes de Medi-Cal, están cubier por medio de un Plan de Salud contrata por el Departamento de Salud del Estado

El Grupo Médico California Plan de Sal Inc., ha hecho un contrato con el Dep tamento de Salud del Estado por los últim seis años y actualmente tiene la más gran cantidad de miembros de Medi-C prepagado en California.

California Medical Group Health Plan, Inc. HEALTH CARE CENTERS

Anaheim/Fullerton Area (M)
1401 Brookhurst Road
Fullerton, CA 92633
(Opening on or about November 1979)

Costa Mesa Medical Group (M)
1755 Orange Ave., Suite A
Costa Mesa, CA 92627

East Long Beach Medical Group (MEVP)
2220 Clark Ave.
Long Beach, CA 90815

El Monte Medical Group (MEDVP)
10454 E. Valley Blvd.
El Monte, CA 91731

Fair Oaks Medical Group (MEDVP)
401 S. Fair Oaks Ave.
Pasadena, CA 91105

Long Beach Regional Dental Care Center
3210 Long Beach Blvd.
Long Beach, CA 90807

North Sepulveda Medical Group (MD)
909 N. Sepulveda Blvd.
El Segundo, CA 90245

North Valley Medical Group (MDVP)
10875 San Fernando Rd.
Pacoima, CA 91331

Olympic Medical Group (MP)
11275 W. Olympic Blvd.
Los Angeles, CA 90064

Orange-Chapman Medical Group (MVP)
1937 W. Chapman Ave.
Orange, CA 92668

Pico Rivera-Downey Medical Group (M)
9155 Telegraph Rd.
Pico Rivera, CA 90660
(Opening on or about April 1979)

Pomona Medical Group (MEDVP)
887 E. Second St.
Pomona, CA 91766

15. Santa Ana Medical Group (MEDP)
    2435 N. Grand Ave.
    Santa Ana, CA 92701
16. Tarzana Medical Group (M)
    5536 Reseda Blvd.
    Tarzana, CA 91356
17. Vermont-Jefferson Medical Group (MEDVP)
    3031 S. Vermont Ave.
    Los Angeles, CA 90007
18. West 57th Street Medical Group (MP)
    805 W. 57th St.
    Los Angeles, CA 90037
19. West San Fernando Valley Area (M)
    7111 Winetka
    Canoga Park, CA 91306
    (Opening on or about June 1979)
20. Wilmington Medical Group (M)
    1250 N. Avalon Blvd.
    Wilmington, CA 90744

M — Medical
Médicos
E — Open 24 hours, 7 days a week
Servicios 24 horas al día
D — Dental
Dentales
V — Vision Care
Cuidado de la visión
P — Pharmacy
Farmacia

Service Locations Available
Fifteen health care centers in Los Angeles, Orange, and San Bernardino Counties. (See map for services available at each center.)

Locales de Servicio Disponibles Para Enrolamiento
En los condados de Los Angeles, Orange y San Bernardino, 15 centros para el cuidado de la salud. (Vea la lista para servicios disponibles.)

Services Available
Twenty-four hour physician services, X-ray, laboratory, pharmacy, dental, optometry (including eyeglasses), emergency transportation and Child Health and Disability Prevention physicals.

Extra Services

Diabetes, hypertension, weight control, smoking control, family planning, and health education.

Physicians Available
General practitioners, family practitioners, pediatricians, obstetricians-gynecologists, and all other specialists as required.

Hospitals Used
Local community hospitals (selected by the plan and plan physicians).

For more information, call the health plan (collect, station to station) at (213) 553-5494 or the Department of Health Services at 1-800-952-5528 (no charge to you).

Servicios Disponibles
Servicios médicos 24 horas al día, rayos X, laboratorio, farmacia, dental, optometría (incluyendo anteojos), transportación de emergencia, y exámenes físicos bajo el Programa Prevencion contra la Desabilidad en la Salud del Niño.

Servicios Extra

Diabetis, hipertensión, control de peso y para no fumar, planeamiento de familia, y educación de salud.

Médicos Disponibles
Médicos en medicina en general, médicos para la familia, obstetricia/ginecología y todas las demás especialidades requeridas.

Hospitales en Uso
Hospitales de la comunidad. (Elegidos por el Plan y sus médicos.)

Para más información, llame al Plan de Salud (llamada por cobrar o de estación a estación) al número 553-5494 o al Departamento de Servicios de Salud a número 1-800-952-5528 (llamada gratuita).

(DHS 5/79)

California State Department of Health Services
455 Capitol Mall, Suite 250
Sacramento, Calif. 95814

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
SACRAMENTO, CA 95814

Appendix B
Mailed Cover Letter
(English Version)

(Vease el otro lado para la version en español)

Dear Medi-Cal Beneficiary:

You can make a choice about your health care. You may continue to receive your benefits with your stickers--from the county hospital or from any private doctor or other provider who will accept your Medi-Cal card. Or you may join a Health Maintenance Organization (HMO) which contracts with the State of California to provide all medically necessary care to eligible Medi-Cal recipients who choose to enroll. You have no costs for Medi-Cal health care under either system.

The information enclosed with this letter will help you select the type of health care which best suits your personal needs and those of your family. Please read it carefully and let us know your choice by filling out the enclosed card and sending it back to us. You will remain eligible for Medi-Cal services whatever you decide, as long as you are eligible for aid.

We want to be sure that you have all the information you need to make your choice. If you have any questions about the information or this letter, you may call the Department of Health Services on our toll-free line (no charge to you), 1-800-952-5528. I encourage you to think it over carefully and make the decision that will provide the best health care services for you and your family.

Sincerely,

Elisabeth H Lyman

Elisabeth Lyman
Deputy Director
Medical Care Standards Division
Department of Health Services

Enclosures

DEPARTMENT OF HEALTH SERVICES
744 P STREET
RAMENTO, CA 95814

(See other side for English version)

Appendix B
Mailed Cover Letter
(Spanish Version)

Estimado beneficiario de Medi-Cal:

Usted puede escoger la clase de servicios médicos que más le convenga para usted y su familia. Puede continuar recibiendo sus beneficios con sus etiquetas, de un hospital del condado, de un médico privado u otro proveedor quien acepte su tarjeta de Medi-Cal; o puede ingresar a una Organización para el Mantenimiento de la Salud (HMO) que tenga contrato con el Estado de California para proveer todos los cuidados médicos necesarios a las personas elegibles a Medi-Cal que deseen enrolarse a este programa.

La información adjunta a esta carta le ayudará a elegir el tipo de cuidados para la salud que mas le convenga, de acuerdo con sus necesidades y las de sue familia. Favor de leer la información cuidadsomente e indícanos su selección, llenando la tarjeta adjunta y devolviéndola al Departamento de Servicios de Salud. Usted seguirá siendo elegible a los servicios gratuitos de Medi-Cal, cualquiera sea su decision, por el tiempo que continue recibiendo asistencia.

Queremos estar seguros de que usted tiene toda la información que necesita para tomar una decisión. Si tiene algunas preguntas acerca de la información en esta carta, por favor llame al Departamento de Servicios de Salud por nuestra línea directa (llamada gratuita), al 1-800-952-5528. Piénselo cuidadosamente antes de decidir quien le dará los mejores servicios para el cuidado de salud y la de su familia.

Sinceramente,

Elisabeth H. Lyman

Elisabeth Lyman
Deputy Director
Medical Care Standards
Department of Health Services

Adjuntos:

Appendix B

Mailed Choice Brochure
(English/Spanish Version)

What's the difference

BETWEEN A MEDI-CAL CARD AND A MEDI-CAL HEALTH MAINTENANCE ORGANIZATION (HMO-PHP)?

¿Cuál es la diferencia

ENTRE UNA TARJETA DE MEDI-CAL Y UN PLAN DE MEDI-CAL (PHP-HMO)?

California State Department of Health Services
155 Capitol Mall, Suite 250
Sacramento, Calif. 95814

Two Kinds of Medi-Cal

Medi-Cal is the State's program for people who need help in paying for health care. If you get a county AFDC check or a gold Social Security check, you have a choice to make about your health benefits. You can choose either the monthly Medi-Cal sticker card program, where you locate your own doctor whenever you need one, or a Medi-Cal prepaid plan, where you get all your services from a single health plan each time you need care. These health plans are now called health maintenance organizations, or HMOs, and they have to meet requirements of both the Federal and State governments.

Although HMOs often provide extra services, either form of Medi-Cal can give you the health care that you and your family need.

Dos Clases de Medi-Cal

Medi-Cal es un programa del Estado para personas que necesitan ayuda económica para pagar servicios médicos para el cuidado de la salud. Si recibe un cheque del condado AFDC (Ayuda para Familias con Niños Dependientes) o un cheque dorado del Seguro Social, usted puede decidir acerca de sus beneficios médicos para el cuidado de su salud.

Usted puede escoger, ya sea el programa regular de Medi-Cal, recibiendo mensualmente una tarjeta de identificación que puede usar con el médico privado que usted escoja cuando lo necisite, o un plan prepagado de Medi-Cal, en donde recibe todos los servicios médicos necesarios dentro de un sólo plan de salud, cada vez que necesite de estos servicios. Estos planes de salud se llaman ahora Organizaciones para el Mantenimiento de la Salud o Health Maintenance Organizations (HMOs), y tienen que satisfacer los requerimientos de los gobiernos Federal y del Estado.

Aún cuando HMOs frecuentemente proveén servicios extra, cualquiera de estos dos programas de Medi-Cal, puede darle los servicios para el cuidado de la salud que usted y su familia necesiten.

What you Can Get From Medi-Cal

These are the basic services that both forms of Medi-Cal provide for you:

- Visits to doctor's offices.
- Hospital and nursing home care when ordered by your doctor.
- Special checkups for children under age 21 and treatment if needed.
- Laboratory and X-ray services.
- Mental health services.
- Dental care.
- Chiropractic services.
- Medications.
- Eyeglasses, hearing aids, medical supplies, and medical equipment when ordered by your doctor.

Lo Que Puede Obtener de Medi-Cal

Estos son los servicios básicos que Medi-Cal, en sus dos formas, provée para usted:

- Visitas a la oficina del médico.
- Hospital y casa de convalecencia para enfermos cuando el médico lo ordene.
- Exámenes para niños hasta la edad de 21 años y tratamiento si es necesario.
- Servicios de laboratorio y rayos X.
- Servicios para la salud mental.
- Servicios dentales.
- Servicios quiroprácticos.
- Medicinas.
- Lentes o anteojos, aparatos para oir suplementos y equipo médico cuando el médico lo ordene.

Advantages and Disadvantages

There are advantages and disadvantages to both kinds of Medi-Cal. You will want to consider them carefully before you decide which kind is best for you and your family.

Included with this brochure is specific information about the HMOs that you may join in your area, including a list of the extra services they provide. As you read the information about the HMOs, here are some things to consider before you decide which kind of Medi-Cal you want:

1. • When you become a member of an HMO, you have to use the HMO's doctors and other services (except if you can't get there in an emergency). • If you have monthly Medi-Cal stickers, you can use any doctor you choose — as long as he or she will take Medi-Cal patients.
2. • When you become a member of an HMO, you sign a contract (enroll) and you have a guaranteed right to medical care. • When you have Medi-Cal stickers, services can be guaranteed available *only* at your county hospital or other county facilities.
3. • In an HMO, there is a grievance system that is set up to try to solve any problems members have with their health plan's services. • If you have a problem with a doctor or other provider under the regular Medi-Cal system, it's up to you to discuss and settle it with the doctor or provider — or to find another to take care of you.
4. • When you become a member of an HMO, you remain a member as long as you continue to receive your AFDC or gold check. If, for some reason, you become unhappy with the HMO, it is possible for you to disenroll. Getting out of the health plan usually takes approximately 60 days. • With a Medi-Cal sticker card, if you become dissatisfied with your doctor, you can leave him or her and try to find another who will accept Medi-Cal patients.

Ventajas y Desventajas

Los dos programas de Medi-Cal, con etiquetas y prepagado, tienen sus ventajas y desventajas. Usted debe de considerarlos cuidadosamente antes de decidir cuál es el mejor programa para usted y su familia.

Incluida con este folleto es la información específica acerca de los HMOs en su área, con una lista de los servicios extra que proveen a los beneficiarios de Medi-Cal. Cuando lea la información acerca de HMOs, éstas son algunas cosas que debe de considerar antes de decidir qué forma de Medi-Cal desea escoger:

1. • Cuando se subscribe a un HMO tiene que hacer uso de sus médicos y demás servicios (excepto en caso de emergencia cuando la facilidad no sea accesible a Ud.) • Si tiene Medi-Cal con etiquetas puede usar el médico de su preferencia, siempre y cuando el o ella acepte pacientes con Medi-Cal.
2. • Cuando se subscribe a un HMO, es como si firmara un contrato que le garantiza sus derechos a recibir cuidados para la salud. • Cuando tiene Medi-Cal con etiquetas, servicios médicos pueden ser garantizados a su disposición *solamente* en el hospital y otras facilidades de su condado.
3. • En un HMO hay un sistema de quejas que sirve para resolver cualquier problema que un subscriptor pueda tener con los servicios del plan de salud al que pertenece. • Si tiene un problema con el médico u otro proveedor bajo el sistema de Medi-Cal con etiquetas, depende de usted el discutirlo y resolverlo con el médico o proveedor, o encontrar a otro que se haga cargo de usted.
4. • Cuando se subscribe a un HMO, usted sigue siendo miembro por tanto tiempo como continúe recibiendo su cheque AFDC o un cheque dorado. Sin embargo, si por alguna razón usted ya no esta satisfecho con HMO, puede desenrolarse y dejar el plan de salud, un proceso que se lleva aproximadamente 60 días. • Con Medi-Cal con etiquetas, si usted no está satisfecho con su médico puede dejarlo y encontrar otro quien acepte pacientes de Medi-Cal regular.

5. • When you join an HMO, the HMO will send you a booklet that will tell you where its doctors, pharmacies, and other services are located, what their normal hours are, how to make an appointment for the kind of service you need, and what to do in an emergency. This information can be especially important to you. • There is no similar information package available for regular Medi-Cal, but it is important for you to ask your doctor in advance what to do if your child suddenly runs a fever in the middle of the night.

How to Choose

As long as you continue to receive your AFDC or gold check, you will not have to pay anything for your Medi-Cal benefits — either way. But you should still choose carefully.

For example, if you already have a family doctor who knows you and any health problems you may have, you are probably wise to stay with that doctor if he or she accepts Medi-Cal

5. • Cuando usted se enrola a HMO, esta organización le enviará un libreto que le informará de sus médicos, farmacias y demás servicios; también le informará a dónde están localizados, cuáles son las horas normales de servicio, cómo hacer una cita y que debe de hacer en un caso de emergencia. Esta información es de mucha importancia para usted. • No hay información similar de Medi-Cal con etiquetas, pero es importante que usted pregunta a su médico antes de que debe de hacer si su niño se le enfermera de repente a la media noche.

Como Escoger

Por el tiempo en que continue recibiendo su cheque de AFDC o un cheque dorado, usted no tendrá que pagar nada por los beneficios de Medi-Cal en cualquiera de sus dos formas. Pero aún así, debe de escoger con mucho cuidado.

Por ejemplo, si usted tiene un médico para toda la familia a quien ven con regularidad y sabe qué problemas de salud tienen, sería más prudente quedarse con el mismo médico, si es que acepta pacientes con las

patients. But, if you do not have a family doctor, or if you can't find a doctor who will accept Medi-Cal patients, you may be better off joining an HMO — so that you will not have to try to find a doctor when you or your child become sick.

In making your choice, be sure to consider your whole family. For example, the State requires each HMO to give children who are plan members a full health examination to detect problems *before* they become serious. (This program is called Child Health Disability Prevention — CHDP.) You can get these exams for your children with a regular Medi-Cal card, but you must find a doctor who is willing to provide the service.

When You Decide

When you have made your choice between the two kinds of Medi-Cal, please fill out the enclosed card. It will help us to get the right Medi-Cal identification card to you as soon as possible.

etiquetas de Medi-Cal. Pero si no lo tiene o no puede encontrar un médico que acepta pacientes con etiquetas de Medi-Cal, sería mejor subscribirse a un HMO y evitar el problema de encontrar a última hora un médico que lo atienda cuando usted o su niño se enferman de repente.

Cuando escoja, asegúrese que toma en consideración la familia entera. Por ejemplo, el Estado requiere de cada HMO que de a los niños (hasta la edad de 21 años) miembros del plan, un completo exámen de salud de acuerdo con el programa de Prevención contra la Incapacidad en la Salud del Niño (Child Health Disability Prevention), para descubrir problemas de salud *antes* de que se conviertan en problemas serios. (Usted puede pedir estos servicios de un proveedor de Medi-Cal regular. El Estado no puede requerir de los médicos privados que lleven a cabo estos exámenes, pero sí pagará por ellos.)

Cuando Usted Decida

Cuando usted haya escogido entre las dos formas de Medi-Cal, por favor complete la tarjeta incluída. Nos ayudará para darle la tarjeta de indentificación de Medi-Cal correcta para usted lo más pronto posible.

Appendix B
HMO Brochure - Rockridge

California State Department of Health Services
455 Capitol Mall, Suite 250
Sacramento, Calif. 95814

Rockridge Health Care Plan

The Rockridge Health Care Plan is a health service system which provides continuing care as well as care for major illness and accidents in its primary health center and in other facilities associated with the health care plan. The plan encourages use of its facilities for health maintenance, early disease detection, and prompt medical treatment.

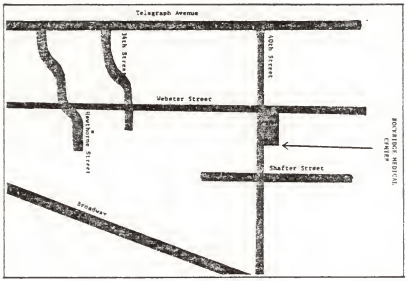
The primary health center is located at 40th and Webster Street. Dental offices and pharmacy are next door.

"ROCKRIDGE" Plan de Cuidados Para la Salud

"Rockridge" Plan de Cuidados para la Salud, es un sistema de servicios para la salud que provee cuidados continuos así como cuidados para enfermedades graves y accidentes en su centro de salud primaria y otras facilidades asociadas con el Plan de Cuidados para la Salud.

El plan ánima a los miembros a usar sus facilidades para el mantenimiento de la salud, temprana detección de enfermedades y su tratamiento, lo más pronto posible.

El centro de salud primaria esta localizado en la esquina de Webster y 40th. Las oficinas para el cuidado dental están al otro lado.



Rockridge Service Area Map

Mapa del Area de Servicios Disponibles del Plan de Salud

Primary Health Centers

Medical Offices:
420 40th Street, Oakland

Service Hours:
9:00 a.m.-8:30 p.m., Monday through Friday
9:00 a.m.-4:30 p.m., Saturday
1:00 p.m.-7:00 p.m., Sunday

Services Provided

Medical — Adult medicine, pediatrics, obstetrics and gynecology, dermatology, ophthalmology, optometry, and others by referral.

Dental

Extra Services

Child care with appointment, mid-wife and alternative birth services, and transportation (bus tokens, ambulance, taxi cab fares paid when necessary for services).

Pharmacy

4001 Webster Street (40th and Webster Streets)

24-Hour Emergency Care

Available by calling the plan's emergency telephone number.

For more information, call the health plan at 653-9930 or the Department of Health Services at 1-800-952-5528 (no charge to you).

Centro de Salud Primaria

Oficinas Médicas: 420 - 40th Street, Oakland

Horas de Servicios:

9:00 a.m.-8:30 p.m., Lunes a Viernes
9:00 a.m.-4:30 p.m., Sabados
1:00 p.m.-7:00 p.m., Domingo

Servicios Disponibles

Servicios Médicos — Medicina para adultos, pediatría, obstetricia/ginecología, especialistas para la piel, oftamología, optometría, y otros servicios si son referidos por el médico

Servicios Dentales

Servicios Extras

Cuidado para los niños provisto por la clínica, servicio de partera, clases de educación para la salud, y transportación — servicio de autobús, ambulancia, y carro de sitio gratis cuando sea necesario.

Farmacia

4001 Webster Street (40th and Webster Street), Oakland

Servicios de Emergencia

Para servicios de emergencia, favor de llamar al teléfono del plan de salud.

Para más información, llame al Plan de Salud al numero 653-9930 o al Departamento de Servicios de Salud al número 1-800-952-5528 (llamada gratuita).

Appendix B

Mail Choice Card - Rockridge (Alameda County) English Version

Please take a few minutes to answer these questions:

1. Do you have a regular source of health care?
   1) ☐ Yes 2) ☐ No
2. If you or a member of your household is sick, where do you usually go for care?
   1) ☐ Private doctor 2) ☐ County clinic
   3) ☐ County hospital 4) ☐ Emergency room
   5) ☐ Other
3. Do you or a member of your household need medical care now? 1) ☐ Yes 2) ☐ No
4. Had you ever heard of Health Maintenance Organizations (HMOs) before you received this?
   1) ☐ Yes 2) ☐ No
5. Have you or a member of your family ever joined an HMO? 1) ☐ Yes 2) ☐ No

Mail back to State Dept. of Health Services — No stamp necessary.

(Vease el otro lado para la version en espanol)

- Please tell us what you have decided about your health care by marking:
  - Box A — Enroll me and my family in an HMO.
  - Box B — I'd like to learn more about HMOs, but keep my sticker card for now.
  - Box C — I'd like to keep my monthly sticker card.

- If you have chosen an HMO, check the box by the plan's name below and tell us how you want to be contacted.

☐ Home Visit ☐ Telephone Call

☐ Rockridge

Here is the choice: (Please give information below for each family member, including yourself.)

Name Last, First, Middle	Relationship to You?	Sex	Birthdate Mo Day Yr	A Enroll in An HMO	B Learn More About HMOs	C Monthly Sticker Card
	(self)					

Print Name	Sign	Date	Phone

Appendix B

Spanish Version

Por favor tómese unos minutos para contestar estas preguntas:

1. ¿Tiene usted un médico de recibir cuidados para la salud regularmente? 1) ☐ Sí 2) ☐ No
2. ¿Si usted o una persona de su casa se enferma, a dónde va, generalmente, por atención médica? 1) Médico privado 2) Clínica del condado 3) Hospital del condado 4) Servicio de emergencia 5) otro
3. ¿Usted o una persona de su casa necesita cuidados médicos ahora? 1) ☐ Sí 2) ☐ No
4. ¿Sabía ya de las Organizaciones para el Mantenimiento de la Salud (HMOs) antes de haber recibido ésta? 1) ☐ Sí 2) ☐ No
5. ¿Nunca ha ingresado, usted o un miembro de su familia, a un HMO? 1) ☐ Sí 2) ☐ No

---

- Por favor díganos que ha decidido acerca de los cuidados para su salud, marcando:

  Cuadro A — Enrolen a mi familia y a mí en un HMO.

  Cuadro B — Deseo tener más información acerca de un HMO. Por ahora me quedaré con mi tarjeta con etiquetas.

  Cuadro C — Deseo quedarme con mi tarjeta con etiquetas mensualmente.

- Si usted ha escogido un HMO, marque el cuadro con el nombre del plan y díganos cómo comunicarnos con usted.

  ☐ ¿Visita en su casa? ☐ ¿Llamada telefónica?

  ☐ "Rockridge" Plan de Ciudados para la Salud

Regrésela al Departamento de Servicios de Salud del Estado — No necesita estampilla.

Esto es lo que escogí: (Por favor dé la información correspondiente por cada miembro de la familia, incluyendose usted mismo)

Nombre. Apellido. Primero. Segundo	¿Qué Relación a Ud.?	Sexo	Fecha de Nacimiento Mes/Día/Año	A Enrolme en un HMO	B Deseo más información	C Guardaré mi tarjeta

Nombre: _____

(letra de imprenta) Dirección Ciudad Zona Postal Teléfono

Firma: _____ Fecha: _____ Número de Medi-Cal. _____

(Favor de copiar los números en el lado izquierdo de su tarjeta, hasta las estrellitas**)

Sample Dual-Choice Presentation
(California Medicaid Program)

Good morning (afternoon). My name is _____. I am here to explain to you how you can receive Medi-Cal benefits if you are determined eligible for aid. Once you are determined eligible for aid, you are entitled to receive health benefits under the Medi-Cal program. I am going to explain the Medi-Cal program now and, at the end of my talk, you will need to tell us how you want to receive your health benefits.

There are two ways to receive Medi-Cal benefits. One way you can receive your health care is by using a monthly Medi-Cal sticker card. Using the sticker card, you must find a doctor, pharmacy, and dentist who will accept the Medi-Cal card and take care of you. The monthly Medi-Cal card will be mailed to you from (Name of issuing agency and location) each month that you are eligible for the cash grant. (If you wish to locate a provider who takes the Medi-Cal card, please call the County Medical Society at _____ or look at the list I will give you.)

You should know that in this area there are (many/few) doctors who take Medi-Cal cards. You should be aware that not all doctors accept Medi-Cal, but the county health facilities always do.

The other way to receive your health care is by joining an HMO or Health Maintenance Organization. Some Health Maintenance Organizations contract with the (Name of state agency) to provide health care to Medi-Cal clients who receive cash grants. Our area does have an HMO to provide services to you, the (Name of HMO). There is no cost to you, if you are determined eligible for the cash grant, for either the (Name of HMO) HMO or the monthly Medi-Cal card. Whether you choose the (Name of HMO) or

the monthly sticker card, you are entitled to the following health services from each:

1. Office visits to the doctor.
2. Hospital or nursing home care.
3. Lab and x-ray services.
4. Mental health services.
5. Prescriptions and medications.
6. Dental care.
7. Eyeglasses, hearing aids, medical supplies, and equipment as ordered by your doctor.
8. Physical, occupational, and other therapy, when your doctor orders it.
9. Special check-ups for children under 21.

Remember that if you choose the monthly sticker card, you must find someone who provides these services and accepts the Medi-Cal monthly sticker card.

If you choose to enroll in the (Name of HMO) it will provide all of these services for you but you must use (Name of HMO) doctors, pharmacies, dentists, and hospitals. You can choose which (Name of HMO) doctor you would like as your family doctor. The (Name of HMO) is located at (Location) and works with (Name of hospitals) hospitals. If you are currently on a treatment program with a doctor and you enroll in (Name of HMO) you will need to transfer your care to a doctor at (Name of HMO) and the plan will help you do this.

(Name of HMO) meets federal and state standards for the provision of medical care. It also offers some additional benefits which are not available with the monthly Medi-Cal sticker card. (Name of HMO) offers midwife and alternative birth services and child care with

appointments.* You also receive a booklet which explains how to use the health plan and obtain your health benefits.

(Name of HMO) also offers 24-hour emergency care which is available by calling the plan's emergency telephone number. If you do enroll in (Name of HMO), you must use the plan's facilities except in an emergency if you are unable to reach the plan. They you can go the nearest emergency facility. With a monthly sticker card you can always receive care at the county hospital.

(Name of HMO) is required to provide children under the age of 21 with child health disability prevention screening, diagnosis, and treatment.

(Some doctors and clinics who accept the monthly Medi-Cal sticker card also provide these services.)

There is no cost to you, if you are determined eligible for the cash grant, for either the (Name of HMO) HMO or the monthly Medi-Cal card.

If you are dissatisfied with the care which you are receiving at (Name of HMO) or with any other aspect of the plan, you can file a complaint with (Name of HMO) and they will attempt to solve your problem. If they cannot solve your problem to your satisfaction, they you can disenroll from (Name of HMO). It will take several months to get a monthly Medi-Cal sticker card after you file your complaint. If you are dissatisfied with the care you are receiving from a doctor, dentist, etc., who takes the monthly Medi-Cal sticker card, you must look for another source of care which takes the monthly sticker card.

*This section is variable depending on HMO benefit package.

Once you are determined eligible for the cash grant, you will receive a monthly Medi-Cal card if you choose to get the card or a membership card from (Name of HMO) if you choose to receive services from them. You should carry your card with you at all times in case of an emergency. Your choice for the (Name of HMO) HMO or the monthly sticker card is completely voluntary. Your monthly AFDC check, food stamps and right to medical benefits will not be affected whichever way you choose.

These common questions are usually asked in deciding which to receive--the sticker card or the (Name of HMO).

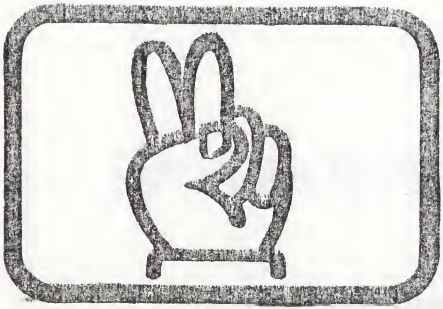
- Where do I get my health care? With the sticker card you can go to any doctor, drug store, or other provider who accepts Medi-Cal. With the HMO you get all your health care from (Name of HMO) except if you can't get there in an emergency.

- How do you know what to do? With the sticker card you should decide which doctors you want to use and find out where they are, if they take Medi-Cal, and what their hours are. With the (Name of HMO) card, (Name of HMO) will send you a booklet which tells you where it is, what its regular hours are and what to do in an emergency. You should be aware that not all doctors accept Medi-Cal, but the county health facilties always do. When you are an HMO member you have the right to receive health care at its facilities whenever medically necessary.

- What if I don't like the health care provider I choose today? If you don't like the services or the care you get with a sticker card, you can talk to your doctor. You may have to locate another doctor who accepts Medi-Cal or you may want to then join (Name of HMO). With the HMO card, (Name of HMO) has a grievance system set up to try to solve your problems and deal with complaints if you don't like the service or care that you get.

- How long do you have to keep the kind of Medi-Cal that you choose today? Well, if you decide later that you would like to join (Name of HMO) and you've chosen a sticker card today, let your worker know or call (Name of HMO) directly. It takes about 45 days to get an HMO card. If you join (Name of HMO) then decide that you would like to get out of it and get a sticker card, you must notify the HMO that you want to leave. It takes several months to change to a sticker card. The pamphlet which you have describes the hours and locations of the (Name of HMO) facilities. Please take a few minutes to look over this material. Then fill out this form that I am passing out. I'll help you complete it if you need help.

The choice is yours!



You may choose:

B-26

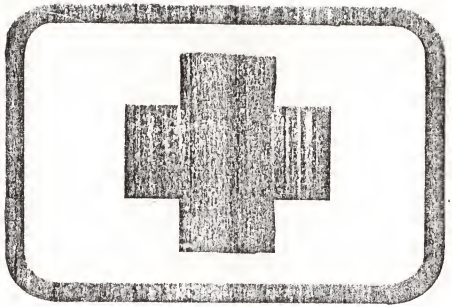
1. To receive a monthly sticker card (you find your own doctors and other providers).
2. To join a Health Maintenance Organization (you get all medically necessary services from the HMO).

Both the monthly sticker card and the HMO card will identify you to receive basic health services, including:

1. office visits to the doctor
2. hospital or nursing home care
3. lab and X-ray services
4. mental health services
5. prescriptions and medications
6. dental care
7. eyeglasses, hearing aids, medical supplies and equipment as ordered by your doctor
8. physical, occupational and other therapy, when your doctor orders it
9. special check-ups for children under 21

Medi-Cal

?	Sticker Card	or	HMO Card
1. Where do I get my health care?	You can go to any doctor, drug store or other provider who accepts Medi-Cal.		You get all your health care from the HMO, except in emergencies.
2. How do I know what to do?	You should decide which doctors you want to use and find out where they are, if they take Medi-Cal, and what their hours are.		The HMO sends you a booklet which tells you: 1. Where it is. 2. What its regular hours are. 3. What to do in an emergency.
3. Do all doctors accept Medi-Cal patients?	Not all doctors accept Medi-Cal, but the county's health facilities always do.		When you are an HMO member, you have a right to receive health care at its facilities whenever medically necessary.
4. What do I do if I don't like the services or care I get?	You can talk to your doctor. You may have to locate another doctor who accepts Medi-Cal.		Each HMO has a grievance system set up to try to solve problems or complaints.
5. How long do I have to keep the kind of Medi-Cal I choose today?	If you decide later that you would like to join an HMO, let your worker know, or call the HMO directly. (It takes about 45 days to get an HMO card.)		If you want to leave you notify the HMO. (It takes about 45 days to change to a sticker card).



Does the HMO in your area provide extra services important to you?

APPENDIX C

Choice-Making Scenarios for Presentations;
Example of County-State Agreement for Demonstration

THE PHRED PROJECT

East Sacramento Office

The Prepaid Health Research, Evaluation and Demonstration (PHRED) Project is supported by a grant from DHEW's Health Care Financing Administration (HCFA). The objective of the Project is to develop model administrative systems and procedures that can be used by any state which contracts with prepaid health plans for the care of Medicaid (Medi-Cal) beneficiaries.

The overall objectives of the project are to: (1) develop and demonstrate systems, materials, and procedures that will serve to inform properly and to educate medicaid beneficiaries about their health care alternatives and to motivate a choice between enrollment in a state-contracted PHP and the fee-for-service (private physicians) system of care, (2) to develop and demonstrate systems and methods which will serve to ensure that those who elect enrollment in a prepaid system will have opportunity to express dissatisfaction and to receive clarification, redress, and the option to disenroll, (3) to develop administrative methods and procedures by which a state can monitor the enrollment of beneficiaries into contracting prepaid health plans and the operations of the plan's grievance disenrollment system.

The intention of the demonstrations in the East Sacramento Office is to determine which method of informing clients of their Medi-Cal options works best: county employee explanation, or written materials without further explanation. Additionally, the PHRED Project will be assessing Plans' current enrollment practices and a mailing to the beneficiaries served by the East Sacramento Office.

To control for variables over time the written materials method will be demonstrated, one day each week at each site. The scheduled demonstration method in progress will be suspended on that day.

Training relevant to the presentation will be given to those staff members concerned shortly prior to the scheduled presentation dates.

The demonstration schedule is as follows:

State representative presentation	6/4/79 to 8/11/79
Mailing	8/13/79 to 9/7/79
PHP representative presentation	9/10/79 to 11/16/79
Current method assessment	11/19/79 to 1/11/80
Eligibility worker presentation	1/14/80 to 3/21/80
Audio visual presentation	3/24/80 to 5/30/80

If you need any assistance or information regarding prepaid health plans in your area, the toll-free number to the Department of Health Services is 1-800-952-5528.

THE PHRED PROJECT

Orange County Westminster Office

The Prepaid Health Research, Evaluation and Demonstration (PHRED) Project is supported by a grant from DHEW's Health Care Financing Administration (HCFA). The objective of the Project is to develop model administrative systems and procedures that can be used by any state which contracts with prepaid health plans for the care of Medicaid (Medi-Cal) beneficiaries.

The overall objectives of the project are to: (1) develop and demonstrate systems, materials, and procedures that will serve to inform properly and to educate medicaid beneficiaries about their health care alternatives and to motivate a choice between enrollment in a state-contracted PHP and the fee-for-service (private physicians) system of care, (2) to develop and demonstrate systems and methods which will serve to ensure that those who elect enrollment in a prepaid system will have opportunity to express dissatisfaction and to receive clarification, redress, and the option to disenroll, (3) to develop administrative methods and procedures by which a state can monitor the enrollment of beneficiaries into contracting prepaid health plans and the operations of the plan's grievance disenrollment system.

The intention of the demonstrations in your office is to determine which method of informing clients of their Medi-Cal options works best: county employee explanation, plan employee explanation, state employee explanation, audio-visual explanation, or written materials without further explanation. Additionally, the PHRED Project will be assessing Plans' current enrollment practices and a mailing to the beneficiaries served by your office.

To control for variables over time the written materials method will be demonstrated, one day each week at each site. The scheduled demonstration method in progress will be suspended on that day.

Training relevant to the presentation will be given to those staff members concerned shortly prior to the scheduled presentation dates.

The demonstration schedule is as follows:

Eligibility worker presentation	5/14/79 to 7/20/79
Mailing	7/23/79 to 8/17/79
Current method assessment	8/20/79 to 10/12/79
Audio-visual presentation	10/15/79 to 12/21/79
PHP representative presentation	12/24/79 to 3/1/80
State representative presentation	3/3/80 to 5/9/80

If you need any assistance or information regarding prepaid health plans in your area, the toll-free number to the Department of Health Services is 1-800-952-5528.

THE PHRED PROJECT

Florence Office

The Prepaid Health Research, Evaluation and Demonstration (PHRED) Project is supported by a grant from DHEW's Health Care Financing Administration (HCFA). The objective of the Project is to develop model administrative systems and procedures that can be used by any state which contracts with prepaid health plans for the care of Medicaid (Medi-Cal) beneficiaries.

The overall objectives of the project are to: (1) develop and demonstrate systems, materials, and procedures that will serve to inform properly and to educate medicaid beneficiaries about their health care alternatives and to motivate a choice between enrollment in a state-contracted PHP and the fee-for-service (private physicians) system of care, (2) to develop and demonstrate systems and methods which will serve to ensure that those who elect enrollment in a prepaid system will have opportunity to express dissatisfaction and to receive clarification, redress, and the option to disenroll, (3) to develop administrative methods and procedures by which a state can monitor the enrollment of beneficiaries into contracting prepaid health plans and the operations of the plan's grievance disenrollment system.

The intention of the demonstrations in your office is to determine which method of informing clients of their Medi-Cal options works best: county employee explanation, plan employee explanation, state employee explanation, audio-visual explanation, or written materials without further explanation. Additionally, the PHRED Project will be assessing Plans' current enrollment practices and a mailing to the beneficiaries served by your office.

To control for variables over time the written materials method will be demonstrated, one day each week at each site. The scheduled demonstration method in progress will be suspended on that day.

Training relevant to the presentation will be given to those staff members concerned shortly prior to the scheduled presentation dates.

The demonstration schedule is as follows:

Current method assessment	6/4/79 to 7/27/79
State representative presentation	7/30/79 to 10/5/79
PHP representative presentation	10/8/79 to 12/14/79
Mailing	12/17/79 to 1/11/80
Audio-visual presentation	1/14/80 to 3/21/80
Eligibility worker presentation	3/24/80 to 5/30/80

If you need any assistance or information regarding prepaid health plans in your area, the toll-free number to the Department of Health Services is 1-800-952-5529.

THE PHRED PROJECT

East Valley Office

The Prepaid Health Research, Evaluation and Demonstration (PHRED) Project is supported by a grant from DHEW's Health Care Financing Administration (HCFA). The objective of the Project is to develop model administrative systems and procedures that can be used by any state which contracts with prepaid health plans for the care of Medicaid (Medi-Cal) beneficiaries.

The overall objectives of the project are to: (1) develop and demonstrate systems, materials, and procedures that will serve to inform properly and to educate medicaid beneficiaries about their health care alternatives and to motivate a choice between enrollment in a state-contracted PHP and the fee-for-service (private physicians) system of care, (2) to develop and demonstrate systems and methods which will serve to ensure that those who elect enrollment in a prepaid system will have opportunity to express dissatisfaction and to receive clarification, redress, and the option to disenroll, (3) to develop administrative methods and procedures by which a state can monitor the enrollment of beneficiaries into contracting prepaid health plans and the operations of the plan's grievance disenrollment system.

The intention of the demonstrations in your office is to determine which method of informing clients of their Medi-Cal options works best: county employee explanation, plan employee explanation, state employee explanation, audio-visual explanation, or written materials without further explanation. Additionally, the PHRED Project will be assessing Plans' current enrollment practices and a mailing to the beneficiaries served by your office.

To control for variables over time the written materials method will be demonstrated, one day each week at each site. The scheduled demonstration method in progress will be suspended on that day.

Training relevant to the presentation will be given to those staff members concerned shortly prior to the scheduled presentation dates.

The demonstration schedule is as follows:

State representative presentation	6/4/79 to 8/11/79
PHP representative presentation	8/13/79 to 10/19/79
Current method assessment	10/22/79 to 12/14/79
Eligibility worker presentation	12/17/79 to 2/22/80
Mailing	2/25/80 to 3/21/80
Audio-visual presentation	3/24/80 to 5/30/80

If you need any assistance or information regarding prepaid health plans in your area, the toll-free number to the Department of Health Services is 1-800-952-5528.

THE PHRED PROJECT

Pittsburg Office

The Prepaid Health Research, Evaluation and Demonstration (PHRED) Project is supported by a grant from DHEW's Health Care Financing Administration (HCFA). The objective of the Project is to develop model administrative systems and procedures that can be used by any state which contracts with prepaid health plans for the care of Medicaid (Medi-Cal) beneficiaries.

The overall objectives of the project are to: (1) develop and demonstrate systems, materials, and procedures that will serve to inform properly and to educate medicaid beneficiaries about their health care alternatives and to motivate a choice between enrollment in a state-contracted PHP and the fee-for-service (private physicians) system of care, (2) to develop and demonstrate systems and methods which will serve to ensure that those who elect enrollment in a prepaid system will have opportunity to express dissatisfaction and to receive clarification, redress, and the option to disenroll, (3) to develop administrative methods and procedures by which a state can monitor the enrollment of beneficiaries into contracting prepaid health plans and the operations of the plan's grievance disenrollment system.

The intention of the demonstrations in your office is to determine which method of informing clients of their Medi-Cal options works best: county employee explanation, plan employee explanation, state employee explanation, audio-visual explanation, or written materials without further explanation. Additionally, the PHRED Project will be assessing Plans' current enrollment practices and a mailing to the beneficiaries served by your office.

To control for variables over time the written materials method will be demonstrated, one day each week at each site. The scheduled demonstration method in progress will be suspended on that day.

Training relevant to the presentation will be given to those staff members concerned shortly prior to the scheduled presentation dates.

The demonstration schedule is as follows:

Current method assessment	4/16/79 to 6/8/79
PHP representative presentation	6/11/79 to 8/17/79
Mailing	8/20/79 to 9/15/79
State representative presentation	9/17/79 to 11/23/79
Audio-visual presentation	11/26/79 to 2/1/80
Eligibility worker presentation	2/4/80 to 4/11/80

If you need any assistance or information regarding prepaid health plans in your area, the toll-free number to the Department of Health Services is 1-800-952-5528.

THE PHRED PROJECT

Contra Costa County Richmond Office

The Prepaid Health Research, Evaluation and Demonstration (PHRED) Project is supported by a grant from DHEW's Health Care Financing Administration (HCFA). The objective of the Project is to develop model administrative systems and procedures that can be used by any state which contracts with prepaid health plans for the care of Medicaid (Medi-Cal) beneficiaries.

The overall objectives of the project are to: (1) develop and demonstrate systems, materials, and procedures that will serve to inform properly and to educate medicaid beneficiaries about their health care alternatives and to motivate a choice between enrollment in a state-contracted PHP and the fee-for-service (private physicians) system of care, (2) to develop and demonstrate systems and methods which will serve to ensure that those who elect enrollment in a prepaid system will have opportunity to express dissatisfaction and to receive clarification, redress, and the option to disenroll, (3) to develop administrative methods and procedures by which a state can monitor the enrollment of beneficiaries into contracting prepaid health plans and the operations of the plan's grievance disenrollment system.

The intention of the demonstrations in your office is to determine which method of informing clients of their Medi-Cal options works best: county employee explanation, plan employee explanation, state employee explanation, audio-visual explanation, or written materials without further explanation. Additionally, the PHRED Project will be assessing Plans' current enrollment practices and a mailing to the beneficiaries served by your office.

To control for variables over time the written materials method will be demonstrated, one day each week at each site. The scheduled demonstration method in progress will be suspended on that day.

Training relevant to the presentation will be given to those staff members concerned shortly prior to the scheduled presentation dates.

The demonstration schedule is as follows:

Eligibility worker presentation	4/16/79 to 6/22/79
Current method assessment	6/25/79 to 8/17/79
Audio-visual presentation	8/20/79 to 10/26/79
State representative presentation	10/29/79 to 1/4/80
Key Plan representative presentation	1/7/80 to 3/14/80
Mailing	3/17/80 to 4/11/80

If you need any assistance or information regarding prepaid health plans in your area, the toll-free number to the Department of Health Services is 1-800-952-5528.

DEPARTMENT OF HEALTH SERVICES
~~XXXXXXXX~~ 455 Capitol Mall, #250
SACRAMENTO, CA 95814
(916) 322-4616

Date: _____

Dear _____ :

The purpose of this letter is to confirm the tentative agreement reached at the _____, 1979 meeting concerning the Prepaid Health Research, Evaluation, and Demonstration (PHRED) Project demonstrations in your county.

The project will commence May 1, 1979 and run through April 12, 1980.

During the implementation and operation of the demonstration, the State will be responsible for the following activities:

1. Describe all data to be collected and supplied to the Department, identify the target population, and provide all reporting formats, time tables, and procedures.

2. Develop and provide to the County a time schedule for each demonstration within the Project prior to the beginning date of the demonstrations.

3. In conjunction with training staff of the County, develop and provide training to all employees of the County participating in the demonstrations, and their supervisors.

4. In conjunction with the County determine required floor space in the demonstration site(s) for each demonstration.

5. Develop or specify and provide to the County at no cost to the County all material to be used during the term of the Project.

6. Assign a State employee as a demonstration worker.

7. Provide technical assistance to the County during the term of the Project to ensure adherance to data collection and research procedures.

8. Consult with the County on demonstration procedures, time tables, and reporting formats, and modify them, as possible within the research design, to have the least possible effect on on-going County operations.

9. Provide the County with a final report on the outcome of the Project.

During the implementation and operation of this Project, _____ County will be responsible for the following activities:

A. Report all cost data associated with the demonstration in a report format specified by the Department and retain such data for no less than one year following the termination of this agreement.

B. Utilize the time schedule developed by the Department and attached to this agreement for performing specific demonstrations within the Project design.

C. Designate the individual office(s) to be used as demonstration site(s), subject to concurrence by the Department, at least 30 days prior to the effective date of the demonstrations.

D. Provide appropriate floor space, as jointly determined by the Department and County within the demonstration site for each demonstration within the Project design.

E. Assign County employee(s) as demonstration workers or as participants in the Project. (Demonstration worker means any County or State employee, or Prepaid Health Plan representative, who directly presents or makes available to the target population applicable material developed for the Project.)

F. Provide a desk, chairs, telephone, and any other work equipment which the County determines is necessary to all demonstration workers.

G. Provide supervision and clerical services for demonstration workers employed by the County.

H. Provide training time for all County workers participating in the demonstrations and their supervisors.

I. Provide for or allow physical renovation of County-owned demonstration sites if necessary. Agreement as to the necessity for renovation shall be secured from both parties prior to the beginning date of each demonstration within the Project and such renovation will be completed prior to the beginning date of appropriate demonstrations.

J. Provide clerical support, as needed, for collection of data and reporting. All data shall be reported in a format specified by the Department.

K. Allow demonstration workers access to demonstration site(s).

L. Provide translation services, if necessary.

In order for the County to receive reimbursement for participation in the Project, the County must strictly adhere to the County claiming procedures for PHRED Project Demonstrations (Attachment A). Additionally, PHRED staff will, at the end of the Project, compare actual costs expended on the Demonstration Project with amounts claimed. Actual costs will be computed by applying the composite cost per hour for each quarter to the total hours reported on the PHRED Choice and Presentation Information Forms (Attachment B). If there are actual costs which have not been paid through the usual process, adjustment will be made by Medi-Cal.

Your cooperation and participation in the demonstrations is greatly appreciated. The significance of our findings, in terms of how the poor are informed of their medical care options, cannot be overstated and your participation in the demonstrations will aid in strengthening whatever conclusions can be drawn.

Sincerely,

Elizabeth W. Owen
Research Specialist
Membership Studies
PHRED Project

EO/tb

Attachments

County Claiming Procedures for PHRED Project Demonstrations

1. Eligibility workers involved in the PHRED Project record time during the time study month to the appropriate AFDC line (A1 or A2, Intake or Continuing, depending upon the action being taken).

2. Each eligibility worker involved in the PHRED Project maintains a supplemental time study which will document the amount of time spent on the PHRED Project which was charged to AFDC. Compile all supplemental time studies and total.

3. Based upon the current quarterly claim, develop a composite cost per hours for AFDC Eligibility Activity. [(DFA 327.2, line A, Column 3+4+5) = Total AFDC hours (323, line A.5) = Composite cost per hour]

4. Multiply composite cost per hour times Total Hours spent on the PHRED Project as documented by the supplemental time study.

5. Enter amount computed in instruction #4 in 325.2, Group III B.1., Personal Services, as a credit to the AFDC Program. This credit will then be carried forward to the DFA 327.2, line A, Column 6.

6. Enter amount computed in instruction #4 in 325.2, Group VI, Extraneous, and identified as PHRED Project.

7. Forward the claim to Medi-Cal with costs identified in Extraneous. Medi-Cal can then make payment to the County.

Marketing-Enrollment Demonstrations

Duties of the Contractor (County Welfare Department)

1. General

   For all demonstrations, keep and report all data related to cost according to an agreed-upon schedule, using a report format specified by the State; make suggestions and recommendations for improvement in the demonstrations; instruct and train appropriate staff; supervise performance of the demonstrations; allow State reasonable access to county staff for training and monitoring purposes.

2. Specific

   a. For the demonstration using county workers (2 months):
      (1) Assign worker(s) to project; provide for supervision.
      (2) Provide training (State-supplied) for all affected by demonstrations.
      (3) Provide working space and usual work materials and equipment for demonstration worker(s).

   b. For the demonstration using State staff (2 months):
      (1) Provide necessary space and office equipment, including telephone.
      (2) Provide training (State-supplied) for all county workers relating to the demonstration.

   c. For the demonstration using the film or video-tape presentation (2 months):
      (1) Allocate appropriate space (large room for group viewing or smaller space for viewing at individual carrels with cassettes) and facilitate renovation as necessary (State-paid).
      (2) Provide for training (State-supplied) of all affected workers and staff (i.e., for referring EW, supervisors, etc.).
      (3) Supply clerical services (if required by procedure to be agreed-upon) for collection of all choice cards after viewing film.

   d. For the demonstration using written materials alone (2 months):
      (1) Provide training (State-supplied) for all affected EWs and supervisors (plus receptionists, if required by procedure to be agreed-upon).
      (2) Provide for services of EWs or clerks to assure that every beneficiary receives information and returns choice-card during eligibility process.

   e. For the demonstration using PHP staff (2 months):
      (1) Allocate space, equipment and telephone service for staff from PHP(s). (Note: If group intake is employed, no space on-site will be required.)
      (2) Provide for training (State-supplied) of all affected staff so that beneficiary is offered information and referred to PHP representative if interested in enrollment. (Note: In situations in which intake is in group meetings, allow the PHP representative to make brief oral presentations and have intake worker provide similar information about the fee-for-service system.)

(3) Provide for services of either EWs or clericals to assure that each beneficiary is offered information and that all make a choice on choice cards.

Duties of the State

1. General

For all demonstrations, describe all data required and provide a reporting format and schedule; discuss demonstration procedures and modify, as possible within research design, to have the least possible effect on on-going county operations; monitor the progress of all demonstrations; supply materials and cover costs directly related to added requirements.

2. Specific

a. For the demonstration using county workers (2 months):
   (1) Provide training.
   (2) Provide demonstration materials.
   (3) Monitor progress of the demonstration and adherance to research procedures, making suggestions for changes or improvements through supervisors.

b. For the demonstration using state workers (2 months):
   (1) Provide staff.
   (2) Provide training and necessary materials for all EWs to give to eligibles.

c. For the demonstration using the audio-visual presentation (2 months):
   (1) Provide film or video-tape version of presentation as suited to site.
   (2) Provide equipment for viewing.
   (3) Pay for any necessary renovations to county premises to allow viewing.
   (4) Provide necessary written supporting materials.
   (5) Provide for training of all county staff affected by demonstration or relating to it.

d. For the demonstration using written materials alone (2 months):
   (1) Supply all necessary materials.
   (2) Provide training for all county staff disseminating materials and/or collecting choice cards.

e. For the demonstration using PHP staff (2 months):
   (1) Arrange with PHP(s) for the assignment of representatives to the demonstration and for their supervision.
   (2) Provide training and information for all county staff relating to the demonstration.
   (3) Provide directly, and indirectly (from PHPs), all necessary written materials.

APPLICATION PROCESS	DEMONSTRATION PROCESS	FORMS
. Applicant goes to reception desk. If new application or reapplication, receptionist completes Form 10-9, Waiting Room Contact. Applicant is given CA-1 to complete while waiting. Applicant takes a number and waits.		County Form 10-9 CA-1
. Reception desk sees applicants in numerical order. Receptionist goes over CA-1 with applicant. Receptionist completes Form 10-16A for open case check. Receptionist schedules applicant for group intake (usually the next morning if redetermination, clients are scheduled 3 weeks in advance.) Receptionist gives applicant a packet with forms to fill out for group intake and a letter explaining which documents to bring in. (If redetermination this material is mailed out by the E.W.'s.	a) Receptionist distributes Basic Information Form and State Brochure	CA-1 County Form 10-16A Packet Basic Information Fo State Brochure CA-2 DFA-285 WR 2.1
. Applicant goes home.		
. Applicant arrives for group intake at 8:30 a.m. (Redetermination is scheduled for 1:30 p.m.). Group intake worker conducts session!		

OUNTY: ALAMEDA

FFICE: NORTH OAKLAND

GROUP INTAKE DEMONSTRATION STRATEGY

APPLICATION PROCESS	DEMONSTRATION PROCESS	FORMS
. Applicants turn in all forms to group intake worker.	c) Group intake worker collects Basic Information Forms. d) Group intake worker distributes Choice and Presentation Information Form (CPIF). e_1) Group intake worker tells applicants to fill in the Choice portion of the CPIF. * No presentation will be made. The worker collects the Choice and Presentation Information Form. OR e_2) Group intake worker explains that applicants have a choice for receiving Medi-Cal benefits. Worker then shows 5 min. film. After film is completed, worker instructs applicants to complete the Choice portion of the CPIF. Worker collects the CPIF OR e_3) Group intake worker gives the presentation on Medi-Cal choices. After presentation, worker instructs applicants to complete the Choice portion of the CPIF. Worker collects the CPIF. OR e_4) Group intake worker introduces PHP representative. Representative gives presentation. Representative leaves room. Worker instructs applicant to complete choice portion of the CPIF. Worker collects the CPIF. OR e_5) Group intake worker introduces State Field Representative. State employee gives presentation, instructs applicants to complete the Choice portion of the CPIF and collects the CPIF.	Choice and Presentation Form (CPIF) Presentation AV Aid for demonstration worker for all demonstrati
. Applicants go to waiting room	f) Group intake worker completes the demonstration portion of the choice and presentation information Form (CPIF).	

APPLICATION PROCESS	DEMONSTRATION PROCESS	FORMS
. Eligibility workers call applicants by name and proceed to interview as necessary.		
. Applicant goes home.	g) Clerical receives Choice Information Presentation Form from group intake worker, and staples to Basic Information Form for each applicant. h) Clerical batches Basic Information Forms under the Choice and Presentation Information Form and places in PHRED box. i) PHRED Field Representative collects forms weekly.	

COUNTY: CONTRA COSTA

INTAKE AND REEVALUATION

CHOICE OFFERED ON FILM PRESENTATION

FILM PROCESS	DEMONSTRATION PROCESS (FILM)	FORMS
1. Division Chiefs (Intake and Re-evaluation) will determine time slots for PHRED. Those clients falling into PHRED time slots will be scheduled 15 minutes early for appointments.		State Brochure Basic Information Form (BI
2. E.W.s of those clients designated as PHRED participants will be notified.		
3. Clients will report to receptionist.		
4. Receptionist will give PHRED clients a State brochure package, which will include a Basic Information Form (BIF) and Choice Presentation Information Form (CAPIF).		Choice and Presentation Information Form (CAPIF)
5. Receptionist will request that PHRED designated clients go to the film area to observe a short film on Medi-Cal Dual Choice.		
6. Receptionist will explain to clients that they are requested to fill out the BIF and the Choice Presentation Information Form(CAPIF) after viewing the movie and to give them to E.W.		
7. Client returns to waiting room after viewing film.	A. E.W. calls client B. E.W. conducts intake or reevaluation interview. C. At end of interview, E.W. collects BIF and CAPIF. D. E.W. completes BIF and demonstration portion of CAPIF. E. Client leaves. F. E.W. assembles all PHRED forms, staples t[illegible]ogether and places them in p[illegible] box	

RICHMOND [illegible]ICE

COUNTY: CONTRA COSTA

4/27/79

INTAKE AND

CHOICE OFFERED ON BROCHURE HAND OUT DAY

HAND OUT PROCESS	DEMONSTRATION PROCESS (BROCHURE)	MATERIALS
1. Client reports to receptionist. 2. Receptionist checks to see if client is AFDC. 3. If client is PHRED AFDC, a package will be given to client* 4. Receptionist will ask client to review Brochure, fill out the Choice portion of the Choice and Presentation Information Form and give it to their worker.	A. E.W. does regular interview. B. At close of interview, E.W. will collect the CPIF and BIF. C. E.W. will complete demonstration portion of the CPIF. D. Client leaves E. E.W. assembles all PHRED forms, staples them together and puts them in PHRED box.	State Brochure Basic Information Form (BIF) Choice and Presentation Information Form (CPIF) PHRED Box

*Welfare office is willing to give the package out to only PHRED designated AFDC clients but not to all AFDC clients coming in the office on brochure day.

APPLICATION PROCESS	DEMONSTRATION PROCESS (E.W. PRESENTATION)	FORMS
. Applicant reports to Receptionist. Applicant is given a CA-1 to fill out. . Applicant fills out forms and returns them to Receptionist. . Receptionist forwards forms to Data Processing, where applicants information is checked to see if there is any current or History files. . Applicant forms are then placed in screening box. Applicants name and the time are entered in the screening daily log. . Intake screener calls applicants for interview. During interview potential classification is determined. . Screener then calls Receptionist for appointment. If applicant is AFDC, screener will indicate this to Receptionist. . At the time the appointment is made if the applicant is placed in one of the time slots that have been designated as PHRED, the Receptionist will schedule the interview 15 minutes earlier than usual and notify the screener that the applicant is PHRED designated		

APPLICATION PROCESS	DEMONSTRATION PROCESS (E.W. PRESENTATION)	FORMS
. If a client is PHRED designated, the screener will include a basic information form to the regular package of forms given the client.		Basic Information Form (BIF)
. The screener will also give the client a State Brochure and ask them to review it prior to their scheduled intake interview.		Brochure
. Applicant leaves.	A. Client checks in with Receptionist.	Choice and Presentation Information Form (CAPIF)
	B. Receptionist notifies E.W.	
	C. E.W. calls client. Reviews forms, interviews client.	
	D. E.W. gives Dual Choice Presentation.	Flip Chart
	E. Gives client the CAPIF and asks them to fill out and sign the choice portion.	
	F. E.W. fills out the demonstration portion of the CAPIF.	
	G. Client leaves.	
	H. E.W. assembles all PHRED forms-staples them together and places them in PHRED box.	

APPLICATION PROCESS	DEMONSTRATION PROCESS (PHP REPRESENTATIVE PRESENTATION)	FORMS
. Applicant reports to receptionist. Applicant is given a CA-1 to fill out.		
. Applicant fills out forms and returns them to receptionist.		
. Receptionist forwards forms to Data Processing, where applicants information is checked to see if there is any current or History files.		
. Applicant forms are then placed in Screening box. Applicants name and the time are entered in the screening daily log.		
. Intake screener calls applicants for interview. During interview potential classification is determined.		
. Screener then calls receptionist for appointment. If applicant is AFDC, screener will indicate this to receptionist.		
. At the time the appointment is made if the applicant is placed in one of the time slots that have been designated as PHRED, the receptionist will schedule the interview 15 minutes earlier than usual and notify the screener that the applicant is PHRED designated.		
. If a client is PHRED designated, the screener will include a Basic Information Form to the regular pack[illegible] of forms given the client.		Basic Information Form (BIF)

APPLICATION PROCESS	DEMONSTRATION PROCESS (PHP REPRESENTATIVE PRESENTATION)	FORMS
The screener will also give the client a State Brochure and ask them to review it prior to their scheduled intake interview. . Applicant leaves.	A. Client checks in with receptionist. B. Receptionist notifies PHP representative. C. PHP representative calls client, Reviews BIF. D. PHP representative will ask client if they object to having interview taped. Whenever possible interviews will be taped. E. PHP representative gives Dual Choice Presentation. F. Gives client the CAPIF and asks them to fill out and sign the choice portion. G. PHP representative fills out demonstration section of the CAPIF. H. Client returned to waiting room. I. If client is late for interview, PHP representative will give presentation after E.W. interview. J. PHP representative assembles all PHRED forms, staples them together and places them in PHRED box. along with daily tapes.	Brochure Choice and Presentation Information Form (CAPIF) Tape Recorder, tapes

APPLICATION PROCESS	DEMONSTRATION PROCESS (STATE REPRESENTATIVE PRESENTATION)	FORMS
. Applicant reports to receptionist. Applicant is given a CA-1 to fill out. . Applicant fills out forms and returns them to receptionist. . Receptionist forwards forms to Data Processing, where applicants information is checked to see if there is any current or History files. . Applicant forms are then placed in Screening box. Applicants name and the time are entered in the screening daily log. Intake screener calls applicants for interview. During interview potential classification is determined. . Screener then calls receptionist for appointment. If applicant is AFDC, screener will indicate this to receptionist. At the time the appointment is made if the applicant is placed in one of the time slots that have been designated as PHRED, the receptionist will schedule the interview 15 minutes earlier than usual and notify the screener that the applicant is PHRED designated.		

APPLICATION PROCESS	DEMONSTRATION PROCESS (STATE REPRESENTATIVE PRESENTATION)	FORMS
. If a client is PHRED designated the screener will include a Basic Information Form to the regular package of forms given the client.		Basic Information Form (BIF)
. The screener will also give the client a State Brochure and ask them to review it prior to their scheduled intake interview.		Brochure
. Applicant leaves.	A. Client checks in with receptionist. B. Receptionist notifies State Representative. C. State representative calls client. Reviews BIF. D. State representative gives Dual Choice Presentation. E. Gives client the CAPIF and asks them to fill out and sign the choice portion. F. State representative fills out the demonstration section of the CAPIF. G. Client returned to waiting room. H. State representative assembles all PHRED forms, staples them together and retains them. I. If client is late for interview, State representative will give presentation after E.W. interviews.	Choice and Presentation Information Form (CAPIF)

RE-EVALUATION PROCESS	DEMONSTRATION PROCESS (E.W. PRESENTATION)	FORMS
. Files for re-evaluation pulled per schedule. . Files reviewed, appointments scheduled. . Necessary forms and appointment time and date mailed to client. . If client appointment is scheduled in one of the time slots designated for PHRED, the appointment will be scheduled 15 minutes earlier then usual, and the E.W. involved notified. . If a client is PHRED designated, a Basic Information Form, and a State Brochure (with an explanation that the dual Medi-Cal Choice will be discussed at the interview) will be added to the package to be mailed to the clients.	A. Client checks in with receptionist. B. Receptionist notifies E.W. C. E.W. calls client, reviews forms, interviews client. D. E.W. gives Dual Choice presentation. E. Gives client the CAPIF and asks them to fill out and sign the choice portion. F. E.W. fills out the demonstration section of the CAPIF. G. Client leaves. H. E.W. assembles all PHRED forms-staples them together and places them in PHRED box.	Basic Information Form (BIF) State Brochure Explanation Memo Choice and Presentation Information Form (CPIF)

RE-EVALUATION PROCESS	DEMONSTRATION PROCESS (PHP REPRESENTATIVE)	FORMS
1. Files for re-evaluation pulled per schedule. 2. Files reviewed, appointments scheduled. 3. Necessary forms and appointment time and date mailed to client. 4. If client appointment is scheduled in one of the time slots designated for PHRED, the appointment will be scheduled 15 minutes earlier than usual. 5. If a client is PHRED designated, a Basic Information Form, and a State Brochure (with an explanation memo) will be added to the package to be mailed to the client.	A. Client checks in with receptionist. B. Receptionist notifies PHP Representative. C. PHP representative calls client, reviews BIF. D. Asks client if they may tape interviews. E. Gives client Dual Choice Presentation. F. Gives client the CAPIF and asks them to fill out and sign the choice portion. G. PHP representative fills out the demonstration portion of the CAPIF. H. Client returned to waiting room. I. PHP representative assembles all PHRED forms, staples them together and places them in PHRED box. J. PHP representative places tapes used for that day in PHRED box at end of each day.	Basic Information Form (BIF) State Brochure Explanation Memo Choice and Presentation Information Form (CAPII

CHOICE OFFERED DURING RE-EVALUATION

RE-EVALUATION PROCESS	DEMONSTRATION PROCESS (STATE PRESENTATION)	FORMS
1. Files for re-evaluation pulled per schedule. 2. Files reviewed, appointments scheduled. 3. Necessary forms and appointment time and date mailed to client. 4. If client appointment is scheduled in one of the time slots designated for PHRED, the appointment will be scheduled 15 minutes earlier than usual. 5. If a client is PHRED designated a Basic Information Form and a State Brochure (with an explanation memo) will be added to the package to be mailed to the clients.	A. Client checks in with receptionist. B. Receptionist notifies State representative. C. State Representative calls client, reviews BIF. D. Gives Dual Choice Presentation. E. Gives client the CAPIF and asks them to fill out and sign the choice portion. F. State representative fills out the demonstration portion of the CAPIF. G. Client returned to waiting room. H. State representative assembles all PHRED forms, staples them together and retains them.	Basic Information Form (B State Brochure Explanation Memo Choice and Presentation Information Form (CAPI

COUNTY: [redacted]nge

CHOICE OFFERED DUR[redacted]NTAKE FOLLOW-UP INTERVIEW
(INTAKE & REDETERMINATION)

Revised 4-15-7[redacted]

Application Process	Demonstration Process EW Method	Forms Materials
1. Applicant goes to reception window, notifies receptionist of his/her appointment.		
2. Receptionist informs EW of applicant's arrival.	1. Receptionist gives applicant PHRED pamphlet and BIF and instructs her/him to read pamphlet and complete BIF while waiting for EW.	PHRED pamphlet Basic Information Form (BIF)
	2. Applicant reads pamphlet and completes BIF.	
3. EW interviews applicant and assists in completion of required forms.	3. EW hands applicant the CAPIF, gives the presentation (using flip chart), & has the applicant complete and return CAPIF. EW collects BIF and staples to CAPIF.	Flip chart
4. EW closes interview and directs applicant to next step in application process.	4. EW completes appropriate section of CAPIF and puts in PHRED basket.	Choice and Presentation Information Form (BIF)
	5. PHRED rep collects all project data on a weekly basis.	

DUNTY: Orange

CHOICE OFFERED DURING INTAKE FOLLOW-UP INTERVIEW

Revised 4/15/79

(INTAKE & REDETERMINATION)

Application Process	Demonstration Process Pamphlet Method	Forms
. Applicant goes to reception window, notifies receptionist of his/her appointment.		
. Receptionist informs EW of applicant's arrival.	1) Receptionist gives applicant PHRED pamphlet and BIF and instructs him/her to read pamphlet and BIF, complete BIF while waiting for EW.	PHRED pamphlet Basic Information Form (BIF)
	2) Applicant reads pamphlet and completes BIF.	
. EW interviews applicant and assists in completion of required forms.	3) EW collects BIF, gives applicant CAPIF and instructs her/him to complete and return it.	
. EW closes interview and directs applicant to next step in application process.	4) EW completes appropriate section of CAPIF and places CAPIF and BIF in PHRED basket	Choice and Information Form (CAPIF) PHRED basket
	5) PHRED rep collects all project data on a weekly basis.	
	Note: BIF will be necessary for only <u>three</u> applicants on pamphlet day.	

COUNTY: [redacted]ANGE

, CHOICE OFFERED DURI[redacted]TAKE FOLLOW-UP INTERVIEW
(INTAKE & REDETERMINATION)

Revised 4-1[redacted]

Application Process	Demonstration Process PHRED Rep	Forms/Materials Resources
1. Applicant goes to reception window, notifies receptionist of his/her appointment.		
2. Receptionist informs EW of applicant's arrival.	1. Receptionist gives applicant PHRED pamphlet and BIF, and instructs her/him to read pamphlet and complete BIF while waiting for EW.	PHRED pamphlet Basic Information Form (BIF)
	2. Applicant reads pamphlet and completes BIF.	
3. EW interviews applicant and assists in completion of required forms.	3. EW collects BIF and staples it to CAPIF, EW completes appropriate section of CAPIF and gives to PHRED rep.	Choice and Presentation Form (CAPIF)
	4. EW accompanies applicant to PHRED representative who gives presentation and instructs applicant to complete CAPIF.	
	5. PHRED Rep collects all forms.	

COUNTY: ORANGE

Revised 4-15-79

CHOICE OFFERED DURING INTAKE FOLLOW-UP INTERVIEW
(INTAKE & REDETERMINATION)

Application Process	Demonstration Process AV Method	Forms/Equip.
1. Applicant goes to reception window, notifies receptionist of his/her appointment.		
2. Receptionist informs EW of applicant's arrival.	1. Receptionist gives applicant PHRED pamphlet and BIF and instructs her/him to read pamphlet and complete BIF while waiting for EW.	PHRED pamphlet Basic Information Form (BIF)
	2. Applicant reads pamphlet and completes BIF.	
3. EW interviews applicant and assists in completion of required forms.	3. EW staples BIF to CAPIF and completes appropriate section of CAPIF which EW gives to applicant then directs her/him to movie viewing area and explains that after viewing movie, applicant is to make a choice on the card and hand it to the receptionist.	AV Equipment Choice & Presentation Information Form
	4. Receptionist places CAPIF in PHRED basket.	PHRED basket
	5. PHRED rep collects all PHRED data on a weekly basis.	

OUNTY: [redacted]ge

Revised [redacted]79

CHOICE OFFERED DURI[redacted]TAKE FOLLOW-UP INTERVIEW

(INTAKE & REDETERMINATION)

Application Process	Demonstration Process PHP Rep. Method	Forms
Applicant goes to reception window, notifies receptionist of his/her appointment.		
Receptionist informs EW of applicant's arrival.	1. Applicant is given PHRED pamphlet and BIF and instructed to complete BIF after reading pamphlet.	PHRED pamphlet
	2. Applicant reads pamphlet and completes BIF.	Basic Information Form (BIF)
EW interviews applicant and assists in completion of required forms.	3. EW staples BIF to CAPIF, completes appropriate section of CAPIF and accompanies applicant to PHP rep. EW gives CAPIF to PHP rep.	
	4. PHP rep. gives presentation, completes appropriate section of CAPIF and instructs client to complete CAPIF.	Choice and Presentation Form (CAPIF)
	5. PHP rep leaves room while applicant completes CAPIF.	
	6. Applicant gives completed CAPIF to receptionist who places it in PHRED basket.	PHRED basket

REVISED 5-17-79

COUNTY: Los Angeles

OFFICE: East Valley

CHOICE OFFERED DURING REDETERMINATION

Application Process	Demostration Process PHRED Rep. Method	Forms
Client is notified by mail of redetermination appiontment. Client notifies receptonist of her/his appointment. EW interviews client.	1. Redetermination packet includes PHRED brochure and BIF. 2. Client reads brochure and complete, BIF proir to appointment. 3. EW collects BIF, completes appropaite section of CAPIF, and accompanies client to PHRED Rep. PHRED Rep. cpllects forms. 4. PHRED Rep. gives presentation, cpmpletes CAPIF and escorts client to Reception Area or to next step in priors as designed by EW. 5. If client has to be escorted someplace other than Recepton Area at the conclusion of PHRED presentation, EW will note place on right hand cover of BIF.	PHRED Brochure Basic Information Form (BIF) Chioce and Presentation Information Form (CAPIF)

COUNTY: Los Angeles
OFFICE: East Valley

CHOICE OFFERED DURING DETERMINATION

Revised 4-17

Application Process	Demonstration Process PHP Method	Forms/Equip.
1. Client notifies receptionist of his/her appointment	1. Receptionist gives client PHRED pamphlet and BIF and instructions.	PHRED Pamphlet Basic Information Form (BIF)
2. Receptionist informs EW of clients arrival	2. Client reads pamphlet and completes BIF.	
3. EW interviews client and assists in completion of required forms	3. EW completes appropriate section of CAPIF and staples it to BIF, explains to client that she/he has to see someone else, and accompanies her/him to PHRED office. EW gives CAPIF to PHP rep.	Choice and Presentation Information Form (CAPIF)
	4. PHP rep. gives presentation, completes appropriate section of CAPIF, instructs applicant to complete CAPIF and leaves room.	
	5. Client completes CAPIF and gives forms to receptionist who places them in PHRED basket.	PHRED basket

COUNTY: Los Angeles

OFFICE: East Valley

Revised 4-17-79

CHOICE OFFERED DURING REDETERMINATION

Application Process	Demonstration Process EW Method	Forms
1. Client notifies receptionist of his/her appointment.	1. Receptionist gives client PHRED pamphlet and BIF instructs him/her to read and complete while waiting for EW.	PHRED pamphlet Basic Information Form (BIF)
2. Receptionist informs EW of client's arrival.	2. Client completes BIF and reads pamphlet	
3. EW interviews client and assists in completion of required forms.	3. EW gives PHRED presentation (using flip chart). EW gives client CAPIF and instructs client to complete and return it. EW staples BIF to CAPIF.	Flip chart Choice and Presentation INformation Form (CAPIF)
4. EW closes interview and directs client to next step in application process.	4. EW completes CAPIF and places it in PHRED basket.	
	5. PHRED rep collects all project data.	PHRED basket.

COUNTY: [illegible]s Angeles
OFFICE: [illegible]ast Valley

CHOICE OFFE[illegible]URING REDETERMINATION

Revised 4-[illegible]

Application Process	Demonstration Process AV Method	Forms
1. Client notifies receptionist of his/her appointment.	1. Receptionist gives client PHRED pamphlet and BIF and instructs him/her to read and complete while waiting for EW.	PHRED pamphlet Basic Information Form (BIF)
2. Receptionist informs EW of client's arrival	2. Client completes BIF and reads pamphlet.	
3. EW interviews client and assists in completion of required forms.	3. EW completes appropriate parts of CAPIF and staples it to BIF, gives client the CAPIF and explains that he/she will see a movie, then complete the CAPIF and hand it to the receptionist before leaving. EW directs or accompanies client to AV booth.	Choice and Presentation Information Form (CAPIF)
	4. Client gives CAPIF to receptionist who places it in PHRED basket.	PHRED basket
	5. PHRED rep collects all data.	

COUNTY: Los Angeles

Revised 5-17-79

OFFICE: East Valley

CHOICE OFFERED DURING REDETERMINATION

Application Process	Demostration Process Brochure Method	Forms
Client is notified by mail of redetermination appointment.		
Client notifies receptionist of her/his appointment.		
EW interviews client.	1. Redetermination packet includes PHRED brochure and BIF.	PHRED brochure Basic Information Form (BIF)
	2. Client reads brochure and completes BIF prior to appointment.	
	3. EW collects and staples BIF to CAPIF, gives CAPIF to client and instructs her to complete and return it	Choice and Presentation Information Form (CAPIF)
	4. EW completes appropiate section of CAPIF.	
	5. EW places CAPIF in PHRED basket.	PHRED Basket

COUNTY: Los Angeles

OFFICE: East Valley

Revised 4-17-79

CHOICE OFFERED DURING INITIAL APPLICATION

Application Process	Demostration Process Brochure Method	Forms/Equip.
Applicant goes to information window. Applicant is given application packet and instructed to complete and return screening forms.		
Applicant takes seat in waiting room and complete screening forms.		
Applicant gives completed screening forms to receptionist who notifies assigned intake worker.	1. Receptionist gives applicant PHRED pamphlet and BIF and instructs her/him to read and complete.	Basic Information Form (BIF) PHRED Brochure
Intake worker accompanies applicant to interview booth.	2. Intake worker collects and staples BIF to CAPIF, gives applicant CAPIF, (and instructs applicant to complete and return it, to worker). Applicant may read or re-read pamphlet if necessary.	Choice and Presentation Information Form (CAPIF)
Intake worker interviews and assists applicants, as necessary, with completion of application.	3. EW complete CAPIF.	
	4. EW places CAPIF in PHRED basket.	PHRED Basket
	5. PHRED rep. collects all project data.	

COUNTY: Los Angeles

OFFICE: East Valley

Revised 5-17-79

CHOICE OFFERED DURING INITIAL APPLICATION

Application Process	Demostration Process PHRED REP	Forms
Applicant goes to information window. Applicant is given application packet and screening forms and instructed to complete screening forms. Applicant takes seat in waiting room and completes screening forms. Applicant gives completed forms to receptionist who notifies assigned intake worker (EW). EW accompanies applicant to interview booth. Ew interviews and assists applicants, as necessary, with completion of application.	1. Receptionist gives applicant PHRED pamphlet and instructs applicant to read it while waiting to be interviewed. Applicant is also given BIF and instructed to complete. 2. EW completes appropriate sections Of CAPIF and staples to BIF which is collected from applicant. 3. EW accompanies applicant to PHRED representative and gives rep. CAPIF. PHRED representative gives presentation and instructs applicant to complete CAPIF. 4. PHRED rep. escorts applicant to next step in process as designed by EW. 5. If client has to be escorted to any place other than reception area, EW will note the place on the right hand corner of the BIF.	PHRED pamphlet Basic Information Form (BIF) Choice and Presentation Information Form (CAPIF)

RE-EVALUATION PROCESS	DEMONSTRATION PROCESS (FILM)	FORMS
Files for re-evaluation pulled per schedule, on AFDC clients.		
Files reviewed, appointments scheduled by E.W.		
When the re-evaluation package is mailed to a client a Basic Information Form and a State Brochure will be included in the package.		Basic Information Form (BIF) State Brochure
	A. Client checks in with receptionist.	
	B. Receptionist makes entries in log, directs all re-evalution clients to viewing area to see film.	
	C. After viewing film client reports back to receptionist.	
	D. E.W. calls client, collects and reviews forms (including BIF) conducts regular interview.	
	E. E.W. has client complete and sign the top portion of CPIF.	Choice & Presentation Form (CPIF)
	F. E.W. reviews top portion of CPIF for completeness and signature, then completes bottom portion of CPIF.	
	G. Client leaves.	
	H. E.W. assembles PHRED forms, staples them together and places them in PHRED box.	

EVALUATION PROCESS	DEMONSTRATION PROCESS (E.W. PRESENTATION)	FORMS
Files for re-evaluation pulled per schedule, on AFDC clients.		
Files reviewed, appointments scheduled, on AFDC clients		
When the re-evaluation package is mailed to a client a Basic Information Form and a State Brochure will be included in the package.		Basic Information Form (BIF) State Brochure
	A. Client checks in with receptionist.	
	B. Receptionist makes entries in log, calls E.W.	
	C. E.W. calls client, collects and reviews forms including BIF, conducts regular interview.	
	D. E.W. gives Dual Choice presentation.	
	E. E.W. has client complete and sign the top portion of CPIF	Choice & Presentation Form (CPIF)
	F. E.W. review top portion of CPIF for completeness and signature, then completes bottom portion of CPIF.	
	G. Client leaves.	
	H. E.W. assemble PHRED forms, staples them together and places them in PHRED box.	

PLICATION PROCESS	DEMONSTRATION PROCESS (STATE REPRESENTATIVE PRESENTATION)	FORMS
. Applicant reports to receptionist who enters applicant's name, the time and date in the log. . Receptionist has applicant complete the top portion of the Screeners Work Sheet (SC-814) and return it to the reception window. . Receptionist then checks the master file to see if there is a current or history file on the applicant. . Receptionist enters applicant's name on interview sheet and places Screeners Work Sheet (SC-814) in screeners box. . Screener calls applicant and lines through applicant's name on interview sheet. . Interviews applicant. Determines potential AFDC eligibility and that the applicant will be serviced by the East Sacramento Office. Makes entry in the log.		

PLICATION PROCESS	DEMONSTRATION PROCESS(STATE REPRESENTATIVE PRESENTATION	FORMS
. Screener calls receptionist for appointment	A. When the screener calls for the appointment, if the applicant's appointment is entered on one of the four lines allocated for PHRED demonstrations (2 at 8:30 a.m. and 2 at 10:00 a.m. except on Thursdays when 2 lines are scheduled for 10:00 a.m. and 2 lines for 1:00 p.m.) the receptionist will notify the screener that the applicant is PHRED designated. The appointment will then be scheduled 15 minutes earlier than usual.	
	B. When an applicant has been PHRED designated, the screener will add a Basic Information Form (BIF) to the regular package of forms given to the applicant to complete prior to their intake interview.	Basic Information Form (BIF)
	C. The screener will also give the applicant a State Medi-Cal brochure and instruct them to read it prior to their intake interview, informing the applicant that their Medi-Cal choices will be discussed with them on the day of their intake interview.	Brochure
. Applicant leaves.	D. Applicant checks in with receptionist.	
	E. Receptionist notifies State representative.	
	F. State representative calls applicant.	
	G. State representative collects and reviews Basic Information Form (BIF). Makes dual choice presentation.	
	H. Following the presentation, the State representative will have the applicant fill out the top portion of the Choice & Presentation Information Form (CPIF).	
	I. State representative will collect the CPIF from the applicant and review it for completeness and signature.	
	J. The State representative will complete the necessary items on the bottom half of the CPIF.	

LICATION PROCESS	DEMONSTRATION PROCESS (STATE REPRESENTATIVE PRESENTATION)	FORMS
	K. State representative will return the applicant to the waiting room and notify the receptionist that they have finished with the applicant. L. State representative will assemble the PHRED forms, staple them together and retain them.	

LICATION PROCESS	DEMONSTRATION PROCESS (FILM)	FORMS
Applicant reports to receptionist who enters applicant's name, the time and date in the log.		
Receptionist has applicant complete the top portion of the Screeners Work Sheet (SC-814) and return it to the reception window.		
Receptionist then checks the master file to see if there is a current or history file on the applicant.		
Receptionist enters applicant's name on interview sheet and places Screeners Work Sheet (SC-814) in screeners box.		
Screener calls applicant and lines through applicant's name on interview sheet.		
Interviews applicant. Determines potential AFDC eligibility and that the applicant will be serviced by the East Sacramento Office. Makes entry in the log.		
Screener calls receptionist for appointment.	A. When the screener calls for the appointment, if the applicant's appointment is entered on one of the four lines allocated for PHRED demonstrations (2 at 8:30 a.m. and 2 at 10:00 a.m. except on Thursdays when 2 lines are scheduled at 10:00 a.m. and 2 lines at 1:00 p.m.) the receptionist will notify the screener that the applicant is PHRED designated. The appointment will then be scheduled 15 minutes earlier than usual.	

LICATION PROCESS	DEMONSTRATION PROCESS (FILM)	FORMS
	B. When the applicant has been PHRED designated, the screener will add a Basic Information Form (BIF) to the regular package of forms given to the applicant to complete prior to their intake interview.	Basic Information Form (BIF)
	C. The screener will also give the applicant a State Medi-Cal brochure and instruct them to read it prior to their intake interview, informing the applicant that their Medi-Cal choices will be discussed with them on the day of their intake interview.	Brochure
Applicant leaves.	D. Applicant checks in with receptionist.	
	E. Receptionist enters in daily log the applicant's name, the time and the intake worker's name.	
	F. Receptionist directs applicant to viewing area to see the film.	
	G. After viewing the film, applicant reports back to the receptionist.	
	H. Receptionist notifies intake worker.	
	I. Intake worker calls applicant. Collects and reviews forms (including BIF). Interviews applicant.	
	J. Intake worker has applicant fill out top portion of Choice & Presentation Form. (CPIF)	Choice & Presentation Form (CPIF)
	K. Intake worker collects CPIF and reviews it for completeness and signature.	
	L. Intake worker completes bottom half of CPIF.	
	M. Intake worker assembles PHRED forms, staples them together and places them in the PHRED box.	

LICATION PROCESS	DEMONSTRATION PROCESS (INTAKE E.W. PRESENTATION)	FORMS
Applicant reports to receptionist who enters applicant's name, the time and date in the log.		
Receptionist has applicant complete the top portion of the Screeners Work Sheet (SC-814) and return it to the reception window.		
Receptionist then checks the master master file to see if there is a current or history file on the applicant.		
Receptionist enters applicant's name on interview sheet and places Screeners Work Sheet (SC-814) in screeners box.		
Screener calls applicant and lines through applicant's name on interview sheet.		
Interviews applicant. Determines potential AFDC eligibility and that the applicant will be serviced by the East Sacto. Office. Makes entry in the log.		
Screener calls receptionist for appointment.	When the screener calls for the appointment, if the applicant's appointment is entered on one of the four lines allocated for PHRED demonstrations (2 at 8:30 a.m. and 2 at 10:00 a.m. except on Thursdays when 2 lines are scheduled for 10:00 a.m. and 2 lines for 1:00 p.m.) the receptionist will notify the screener that the applicant is PHRED designated. The appointment will then be scheduled 15 minutes earlier than usual.	

LICATION PROCESS	DEMONSTRATION PROCESS (INTAKE E.W. PRESENTATION)	FORMS
	B. When an applicant has been PHRED designated, the screener will add a Basic Information Form (BIF) to the regular package of forms given to the applicant to complete prior to their intake interview.	Basic Information Form (BIF)
	C. The screener will also give the applicant a State Medi-Cal brochure instruct them to read it prior to their intake interview, informing the applicant that their Medi-Cal choices will be discussed with them on the day of thier intake interview.	Brochure
	D. Applicant checks in with receptionist.	
	E. Receptionist enters on daily log the applicant's name, time of arrival, and the intake worker's name; then notifies the intake worker.	
	F. Intake worker calls applicant. Collects & reviews forms (including BIF) and interviews applicant.	
	G. Intake worker gives dual choice presentation.	
	H. Intake worker has applicant fill out top portion of the Choice & Presentation Information Form (CPIF).	Choice & Presentation Form (CPIF)
	I. Intake worker reviews CPIF, ensures that applicant has completed and signed the CPIF.	
	J. Intake worker completes bottom portion of the CPIF.	
	K. Intake worker assembles PHRED forms, (BIF & CPIF), staples them together and places them in the PHRED box.	

LICATION PROCESS	DEMONSTRATION PROCESS (BROCHURE DAY)	FORMS
Applicant reports to receptionist, who enters applicant's name, the time and date in the log.		
Receptionist has applicant fill out top portion of Screeners Work Sheet (SC-814) and returns it to reception window.		
Receptionist then checks master file to see if there is a current or history file on the applicant.		
If applicant is requesting AFDC and resides in the zip code area served by the East Sacramento Office, receptionist will give applicant(s) a State Brochure and ask them to read it while waiting to see their screener.		State Brochure
Receptionist enters applicant's name on interview sheet and places the Screener Work Sheet (SC-814) in screener's box.		
Screener picks up screening sheet. Calls applicant, lines through applicant's name on interview sheet.		
Screener reviews form interviews applicant and enters client's name and the disposition in their screener's log.		

PLICATION PROCESS	DEMONSTRATION PROCESS (BROCHURE DAY)	FORMS
	A. If applicant is potential AFDC eligible, and will be serviced by the East Sacramento Office, screener will have the applicant complete the Basic Information Form and the top section of the Choice and Presentation Information Form.	Basic Information Form (BIF) Choice & Presentation (CPIF)
	B. Screener will review forms for completeness and signature.	
Applicant leaves.	C. Screener will complete appropriate sections in the bottom half of the form.	
	D. Screener will attached PHRED forms together and place them in the PHRED box.	

ICATION PROCESS	DEMONSTRATION PROCESS (BROCHURE DAY)	FORMS
	A. Client reports to receptionist.	State brochure
	B. Receptionist makes necessary entries on log. Gives client a State brochure and asks them to read it while waiting for their interview.	
	C. E.W. calls client. Collects and reviews forms. Conducts regular interview for continuing eligibility.	
	D. If client resides within the zip code area serviced by the East Sact. Office the eligibility worker will have the client complete a BIF and a CPIF.	Basic Info. Form (BIF) Choice & Presentation Info. Form (CPIF)
	E. E.W. will collect and review forms for completeness and signature.	
	F. Client leaves.	
	G. E.W. then completes bottom portion of the CPIF, attaches it to the BIF and places them in the PHRED box.	

inty: Sa[illegible]nto (East Sacto. Office) CHOICE OFFERED Date: 6-11-79

Re-[illegible]ualtion

EVALUATION PROCESS	DEMONSTRATION PROCESS (STATE REPRESENTATIVE)	FORMS
Files for re-evaluation pulled per schedule, on AFDC clients. Files reviewed, appointments scheduled by E.W. When the re-evaluation package is mailed to a client, a Basic Information Form and a State Brochure will be included in the package.		Basic Information Form (BIF) State Brochure
	A. Client received from E.W.	
	B. Basic Information Form reviewed.	
	C. Dual Choice presentation made.	
	D. State representative will have client complete top portion of Choice and Presentation Information Form.	Choice & Presentation Information Form (CPIF)
	E. State representative will check client section of the CPIF for completeness and signature.	
	F. State representative will complete bottom portion of form.	
	G. Client returned to waiting room and receptionist notified that State representative has finished with client.	
	H. State representative will assemble all PHRED forms, staple them together and retain them.	

'LICATION PROCESS	DEMONSTRATION PROCESS (PHP PRESENTATION)	FORMS
Applicant reports to receptionist who enters applicant's name, the time and date in the log. Receptionist has applicant complete the top portion of the Screeners Work Sheet (SC-814) and return it to the reception window. Receptionist checks the master file to see if there is a current or history file on the applicant. Receptionist enters applicant's name on interview sheet and places Screeners Work Sheet (SC-814) in screeners box. Screener calls applicant and lines through applicant's name on interview sheet. Interviews applicant. Determines potential AFDC eligibility and that the applicant will be services by the East Sacramento Office. Makes entry in the log.		

LICATION PROCESS	DEMONSTRATION PROCESS (PHP PRESENTATION)	FORMS & MATERIALS
Screener calls receptionist for appointment.	A. When the screener calls for the appointment, if the applicant's appointment is entered on one of the four lines allocated for PHRED demonstrations (2 at 8:30 a.m. and 2 at 10:00 a.m. except on Thursdays when 2 lines are scheduled for 10:00 a.m. and 2 lines for 1:00 p.m.) the receptionist will notify the screener that the applicant is PHRED designated. The appointment will then be scheduled 15 minutes earlier than usual.	
	B. When an applicant has been PHRED designated, the screener will add a Basic Information Form (BIF) to the regular package of forms given to the applicant to complete prior to their intake interview.	Basic Information Form (BIF)
	C. The screener will also give the applicant a State Medi-Cal brochure and instruct them to read it prior to their intake interview, informing the applicant that their Medi-Cal choices will be discussed with them on the day of their intake interview.	Brochure
Applicant leaves	D. Applicant checks in with receptionist.	
	E. Receptionist notifies PHP representative.	
	F. PHP representative calls applicant. PHP representative will not collect the Basic Information Form.	
	G. PHP representative will start recorder and ask applicant if they object to having the interview recorded. If the applicant objects, the recorder will be turned off and the dual choice presentation will be given. If the applicant does not object, the presentation and the remainder of the interview will be taped.	Tape Recorder-Tapes
	H. Following the presentation, the PHP representative will have the applicant fill out the top portion of the Choice & Presentation Information Form (CPIF).	Choice and Presentation Information Form (CPIF)
	I. The PHP representative will collect the CPIF from the applicant and review it to make sure it is complete and to assure that it has been signed by the applicant.	Rep. is in room

unty: Sacramento (East Sacto. Office) CHOICE OFFERED
Re-Evaluation

Date:

-EVALUATION PROCESS	DEMONSTRATION PROCESS (PHP REPRESENTATIVE)	FORMS
Files for re-evaluation pulled per schedule, on AFDC clients.		
Files reviewed, appointments sched scheduled by E.W.		
When the re-evaluation package is mailed to a client a Basic Information Form and a State Brochure will be included in the package.		Basic Information Form (BIF) State Brochure
Upon completion of re-evaluation interview, the E.W. will call the PHP representative and inform her/him that they have a client for the PHRED demonstration.		
E.W. will collect the BIF from the client and put it in PHRED box.	A. Client received from E.W.	
	B. PHP representative will start recorder and ask client if they object to having the interview recorded. If the client objects, the recorder will be turned off and the dual choice presentation given.	Tape Record & Tapes
	C. PHP representative will have client fill out the top portion of the CPIF.	Choice & Presentation Information Form (CPIF)
	D. PHP representative will review top portion (client's section) to see if complete and assure that the client has signed the form.	
	E. The PHP represenative will complete the bottom portion of the form.	

E-EVALUATION PROCESS	DEMONSTRATION PROCESS (PHP REPRESENTATIVE)	FORMS
	F. The PHP representative will return the client to the waiting room and notify the receptionist that they have finished with the client. G. The PHP representative will assemble the PHRED forms, staple them together and place them in the PHRED box. H. The PHP representative will hold the interview tapes until they are collected by the PHRED field presentatives.	

LICATION PROCESS	DEMONSTRATION PROCESS (PHP PRESENTATION)	FORMS
	J. The PHP representative will complete the bottom portion of the form. K. The PHP representative will return the applicant to the waiting room and notify the receptionist that they have finished with the applicant. L. Eligibility workers will collect the Basic Information Form from the client when they collect the County Forms, and assure the the BIF is placed in the PHRED box. M. The PHP representative will place the CPIF in the PHRED box. N. The PHP representative will hold the interview tapes until they are collected by PHRED field representatives.	

nty: P[illegible]URG
Contra Costa
New Applicant

CHOICE OFFERED DURING INTAKE

4/27/79

LICATION PROCESS	DEMONSTRATION PROCESS (BROCHURE DAY)	FORMS
Applicant reports to receptionist, who enters applicants' name, the time and date on the log. The receptionist also enters this information on a "Blue Slip" and places it in the application clerk's box.		
Application clerk collects "Blue Slip" calls client, fills out a Gen I, checks to see if there is a current or history file on applicant. If there is a History file on applicant notes so on Gen I, and places the Gen I in the appropriate E.W. Screener's Box. (If there is a current history the clients E.W. is notified.)		
Application clerk lists on her log type of aid requested.		
Screener calls client. Collects and reviews Gen I, interviews client.		Basic Information Form (BIF) & State Brochure
If client is AFDC eligible, screener will add a State Brochure and a Basic Information Form (BIF) to the package of forms given the applicant, and instructs them to review the Brochure and complete the BIF and bring it with them when they come for their Intake interview.		

LICATION PROCESS	DEMONSTRATION PROCESS (BROCHURE DAY)	FORMS
	A. Client checks in with receptionist.	
	B. Receptionist notifies State representative.	
	C. State representative calls client--reviews BIF.	
	D. Has client fill out top portion of a Choice and Presentation Information Form.	Choice & Presentation Information Form (CAPIF)
	E. State representative then reviews form assuring it has been completed and signed.	
	F. State representative then completes bottom portion of CPIF.	
	G. State representative will explain CHDP to the client, complete the "Purple Card" and have the client give it to their worker.	CHDP Choice Card CHDP Brochure
	H. State representative will return client to waiting room and notify receptionist.	
	I. State representative will assemble all forms, staple them together and maintain them.	
	J. If a client is late for the scheduled interview, the State representative will give the Dual Choice after the E.W. interview.	

ity: PITTSBURG
Contra Costa
New Applicant

CHOICE OFFERED DURING INTAKE

4/27/79

ICATION PROCESS	DEMONSTRATION PROCESS (STATE REPRESENTATIVE PRESENTATION)	FORMS
Applicant reports to receptionist, who enters applicants' name, the time and date on the log. The receptionist also enters this information on a "Blue Slip" and places it in the application clerk's box. Application clerk collects "Blue Slip" calls client, fills out a Gen I, checks to see if there is a current or history file on applicant. If there is a History file on applicant notes so on Gen I, and places the Gen I in the appropriate E.W. Screener's Box. (If there is a current history the clients E.W. is notified.) Application clerk lists on her log type of aid requested. Screener calls applicant for interview. During interview potential classification is determined. Screener calls appointment clerk for appointment, notifies appointment clerk of classification of assistance. When appointment is made, if the applicant is placed AFDC the appointment clerk will schedule the interview fifteen (15) minutes earlier than usual.		Basic Information Form (BIF) State Brochure

PLICATION PROCESS	DEMONSTRATION PROCESS (STATE REPRESENTATIVE PRESENTATION)	FORMS
When a client is PHRED designated, the screener will addaa Basic Information Form to the regular package of forms given to the applicant to complete prior to their intake interview. The screener will also give the applicant a State Brochure and instruct them to read it prior to their intake interview, informing the applicant that their Medi-Cal selection will be discussed with them on the day of their Intake interview. Applicant leaves office.	A. Client checks in with receptionist.	Basic Information Form (BIF)
	B. Receptionist notifies State representative.	State Brochure
	C. State representative calls client--reviews BIF.	
	D. State representative gives Dual Choice presentation.	
	E. Has client fill out top portion of a Choice and Presentation Information Form.	Choice and Presentation Information Form (CPIF)
	F. State representative then reviews form, assures it has been completed and signed.	
	G. State representative then completes bottom protion of CPIF.	
	H. State representative will explain CHDP to the client, complete the "Purple Card" and have the client give it to their worker.	CHDP Choice Card CHDP Brochure
	I. State representative will return client to waiting room and notify receptionist.	

nty: Contra Costa
New Applicant

CHOICE OFFERED DURING INTAKE

LICATION PROCESS	DEMONSTRATION PROCESS (STATE REPRESENTATIVE PRESENTATION)	FORMS
	J. State representative will assemble all forms, staple them together and maintain them. K. If a client is late for the scheduled interview, the State representative will give the Dual Choice after the E.W. interview.	

nty: P[illegible]URG
C[illegible]a Costa
New Applicant

CHOICE OFFERED D[illegible]G INTAKE

4/27/79

LICATION PROCESS	DEMONSTRATION PROCESS (E.W. PRESENTATION)	FORMS
Applicant reports to receptionist, who enters applicants' name, the time and date on the log. The receptionist also enters this information on a "Blue Slip" and places it in the application clerk's box. Appli[illegible]ation clerk collects "Blue Slip" calls client, fills out a Gen I, checks to see if there is a current or history file on applicant. If there is a History file on applicant notes so on Gen I, and places the Gen I in the appropriate E.W. Screener's Box. (If there is a current history the clients E.W. is notified.) Application clerk lists on her log type of aid requested. Screener calls applicant for interview. During interview potential classification is determined. Screener calls appointment clerk for appointment, notifies appointment clerk of classification of assistance. When appointment is made, if the applicant is placed on AFDC, the appointment clerk will schedule the interview fifteen minutes (15) earlier than usual.		Basic Information Fom Form (BIF) State Brochure

LICATION PROCESS	DEMONSTRATION PROCESS (E.W. PRESENTATION)	FORMS
When a client is PHRED designated, the screener will add a Basic Information Form to the regular package of forms given to the applicant to complete prior to their intake interview. The screener will also give the applicant a State Brochure and instruct them to read it prior to their intake interview, informing the applicant that their Medi-Cal selection will be discussed with them on the day of their Intake interview. Applicant leaves office.	A. Client checks in with receptionist. B. Receptionist enters on daily log the client's name and time of arrival, then notifies the Eligibility worker. C. E.W. calls client. Collects and reviews forms, interviews client. D. E.W. give Dual Choice presentation. E. Has client fill out top portion of a Choice and Presentation Information Form. F. E.W. Reviews form, insures that client has completed and signed form. G. E.W. completes bottom portion of form. H. Client leaves. I. E.W. assembles all PHRED forms, staples them together and places them together and places them in PHRED box.	Choice and presentation Information Form

nty: PI URG
C Costa
New Applicant

CHOICE OFFERED D G INTAKE

/79

LICATION PROCESS	DEMONSTRATION PROCESS (PHP PRESENTATION)	FORMS
Applicant reports to receptionist, who enters applicants' name, the time and date on the log. The receptionist also enters this information on a "Blue Slip" and places it in the application clerk's box. Application clerk collects "Blue Slip" calls client, fills out a Gen I, checks to see if there is a current or history file on applicant. If there is a History file on applicant notes so on Gen I, and places the Gen I in the appropriate E.W. Screener's Box. (If there is a current history the clients E.W. is notified.) Application clerk lists on her log type of aid requested. Screener calls applicant for interview. During interview potential classification is determined. Screener calls appointment clerk for appointment, notifies appointment clerk of classification of assistance. When appointment is made, if the applicant is placed on AFDC, the appointment clerk will schedule the interview fifteen (15) minutes earlier than usual.		Basic Information Fom Form (BIF) State Brochure

PLICATION PROCESS	DEMONSTRATION PROCESS (PHP PRESENTATION)	FORMS & MATERIALS
When a client is AFDC designated, the screener will add a Basic Information Form to the regular package of forms given to the applicant to complete prior to their intake interview. The screener will also give the applicant a State Brochure and instruct them to read it prior to their intake interview, informing the applicant that their Medi-Cal selection will be discussed with them on the day of their Intake interview. Applicant leaves office.	A. Client checks in with receptionist. B. Receptionist notifies PHP representative. C. PHP representative calls client, collects and reviews BIF. D. PHP representative will start recorder, ask client if they object to having interview taped. If client objects, machine will be turned off and presentation will continue. E. PHP representative will have client complete top portion of the Choice and Presentation Information Form. F. PHP representative will review top portion of CPIF, assure that client has signed the form, then complete the bottom portion of the form. (CPIF) G. PHP representative will then explain CHDP to client. Upon completion of the interview, the PHP representative will fill out the "Purple Card" give it to the client, who will give it to their worker.	Basic Information Form (BIF) State Brochure Choice and Presentation Information Form Tape recorder Tapes CHDP Choice Card CHDP Brocure

LICATION PROCESS	DEMONSTRATION PROCESS (PHP PRESENTATION)	FORMS
	H. PHP representative returns client to waiting-room--notifies receptionist. I. PHP representative assembles all PHRED forms, staples them together and places them in PHRED Box. J. PHP representative will hold interview tapes until collected by the PHRED Field Representative. K. If client is late for interview PHP representative will see client following E.W. interview.	

PITTSBURG
nty: Contra Costa
New Applicant

CHOICE OFFERED DURING INTAKE

4/27/79

LICATION PROCESS	DEMONSTRATION PROCESS (FILM)	FORMS
Applicant reports to receptionist, who enters applicants' name, the time and date on the log. The receptionist also enters this information on a "Blue Slip" and places it in the application clerk's box. Application clerk collects "Blue Slip" calls client, fills out a Gen I, checks to see if there is a current or history file on applicant. If there is a History file on applicant notes so on Gen I, and places the Gen I in the appropriate E.W. Screener's Box. (If there is a current history the clients E.W. is notified.) Application clerk lists on her log type of aid requested. Screener calls applicant for interview. During interview potential classification is determined. Screener calls appointment clerk for appointment, notifies appointment clerk of classification of assistance. When appointment is made, if the applicant is placed in one of the time slots that have been designated as PHRED, the appointment clerk will schedule the interview fifteen (15) minutes earlier than usual and notify the screener that the applicant is PHRED designated.		Basic Information Fom Form (BIF) State Brochure

nty: Co[illegible]a Costa
New Applicant

CHOICE OFFERED DU[illegible]G INTAKE

4/27/

[illegible]ICATION PROCESS	DEMONSTRATION PROCESS (FILM)	FORMS
When a client is PHRED designated, the screener will add a Basic Information Form to the regular package of forms given to the applicant to complete prior to their intake interview. The screener will also give the applicant a State Brochure and instruct them to read it prior to their intake interview, informing the applicant that their Medi-Cal selection will be discussed with them on the day of their Intake interview. Applicant leaves office.	A. Client checks in with receptionist. B. Receptionist enters on daily log the client's name and time of arrival, then directs client to viewing area to see film. C. After viewing film client reports back to receptionist. D. E.W. calls client. Collects and reviews BIF, interviews client. E. E.W. has client fill out top portion of a Choice and Presentation Information Form. F. E.W. reviews form, insures that client has completed and signed form. G. E.W. completed bottom portion of form. H. Client leaves (CPIF). I. E.W. assembles all PHRED forms, staples them together and places them together and places them in PHRED box.	Choice and presentation Information Form

ty: Contra Costa (Pittsburg) CHOICE OFFERED DURING RE-EVALUATION 4/27/79
RE-EVALUATION

EVALUATION PROCESS	DEMONSTRATION PROCESS (STATE REPRESENTATIVE)	FORMS
Files for re-evaluation pulled per schedule, on AFDC clients. Files reviewed, appointments scheduled by E.W. When the re-evaluation package is mailed to a client a Basic Information Form and a State Brochure will be included in the package.		Basic Information Form (BIF) State Brochure
	A. Client received from E.W. B. Basic Information Form reviewed. C. Dual Choice presentation made. D. State representative will have client complete top portion of Choice and Presentation Information Form. E. State representative will check client section of the CPIF for completeness and signature. F. State representative will complete bottom portion of form. G. Client returned to waiting room and receptionist notified that State represntative has finished with client. H. State representative will assemble all PHRED forms, staple them together and retain them.	Choice and Presentation Information Form

EVALUATION PROCESS	DEMONSTRATION PROCESS (FILM)	FORMS
Files for re-evaluation pulled per schedule, on AFDC clients. Files reviewed, appointments scheduled by E.W. When the re-evaluation package is mailed to a client a Basic Information Form and a State Brochure will be included in the package.		Basic Information Form (BIF) State Brochure
	A. Client checks in with receptionist. B. Receptionist makes entries on log, directs all re-evaluation clients to viewing area to see film. C. After viewing film, client reports back to receptionist. D. E.W. calls client, collects and reviews forms, conducts regular interview. E. E.W. has client complete and sign the top portion of CPIF. F. E.W. reviews top portion of CPIF for completeness and signature, then completes bottom portion of CPIF. G. Client leaves. H. E.W. assembles PHRED forms, staples them together and places them in PHRED box.	Choice and Presentation Information Form

ty: Contra Costa (Pittsburg) RE-EVALUATION

CHOICE OFFERED DURING RE-EVALUATION

4/27/79

EVALUATION PROCESS	DEMONSTRATION PROCESS (BROCHURE DAY)	FORMS
	A. Client checks in with receptionist.	Basic Information Form (BIF)
	B. Receptionist makes entries on log, calls E.W.. Gives client a State brochure and asks them to read it while waiting for their interview.	State Brochure
	C. E.W. calls client, collects and reviews forms, conducts regular interview.	
	D. E.W. has client complete a BIF and the top portion of CPIF.	Choice and Presentation Information Form
	E. E.W. review top portion of CPIF for completeness and signature, then completes bottom portion of CPIF.	
	F. Client leaves.	
	G. E.W. assembles PHRED forms, staples them together and places them in PHRED box.	

E-EVALUATION PROCESS	DEMONSTRATION PROCESS (E.W. PRESENTATION)	FORMS
Files for re-evaluation pulled per schedule, on AFDC clients. Files reviewed, appointments scheduled by E.W. When the re-evaluation package is mailed to a client a Basic Information Form and a State Brochure will be included in the package.	A. Client checks in with receptionist. B. Receptionist makes entries on log, calls E.W. C. E.W. calls client, collects and reviews forms, conducts regular interview. D. E.W. gives Dual Choice presentation. E. E.W. has client complete and sign the top portion of CPIF. F. E.W. review top portion of CPIF for completeness and signature, then completes bottom portion of CPIF. G. Client leaves. H. E.W. assembles PHRED forms, staples them together and places them in PHRED box.	Basic Information Form (BIF) State Brochure Choice and Presentation Information Form

RE-EVALUATION PROCESS	DEMONSTRATION PROCESS (PHP REPRESENTATIVE)	FORMS & MATERIALS
1. Files for re-evaluation pulled per schedule, on AFDC clients.		Basic Information Form (BIF)
2. Files reviewed, appointments scheduled by E.W.		State Brochure
3. When the re-evaluation package is mailed to a client a Basic Information Form and a State Brochure will be included in the package.		
4. Upon completion of re-evaluation interview, the E.W. will call the PHP representative and inform her/him that they have a client for the PHRED demonstration.		
5. E.W. will have client retain BIF and give it to the PHP representative.		
	A. Client received from E.W.	
	B. Basic Information Form reviewed.	
	C. PHP representative will start recorder and ask client if they object to having the interview recorded. If the client objects, the recorder will be turned-off and the dual choice presentation given.	Tape Recorder. Tapes.
	D. PHP representative will have client fill out the top portion of the CPIF.	Choice and Presentation Information Form
	E. PHP representative will review top portion (client's section) see if complete and assure that the client has signed the form.	
	F. The PHP representative will complete the bottom portion of the form.	

APPENDIX D

Data Collection Forms

State of California—Health and Welfare Agency

Department of Health Services

BASIC INFORMATION FOR[illegible]
FOR MEDI-CAL BENEFITS

Appendix D: Data Collection Forms
Item 1
Basic Information Form for Medi-Cal Benefits

PLEASE PRINT YOUR NAME AND ADDRESS IN THE SPACES BELOW:

1. NAME: _____ (Last) _____ (First) _____ (Middle)
2. ADDRESS: _____ (Street Number) _____ (Street or Road) _____ (City)
   _____ (County) _____ (Zip)
3. PHONE NUMBER: ( ) _____ (Area Code) (Number)

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOU AND YOUR FAMILY:

4. What is your birthdate? ___ (Month) ___ (Day) ___ (Year)
5. What is your sex? . . . . . 1) ☐ Female 2) ☐ Male
6. What is your current marital status? (check one) . . . . . 1) ☐ Married 2) ☐ Divorced 3) ☐ Separated 4) ☐ Widowed 5) ☐ Single 6) ☐ Other _____
7. What language is spoken in your home? (check one) . . . . . 1) ☐ English 2) ☐ Spanish 3) ☐ Other _____
8. What is your ethnic group identity? (check one) . . . . . 1) ☐ Asian 2) ☐ Black 3) ☐ Filipino 4) ☐ Hispanic 5) ☐ Native American 6) ☐ White 7) ☐ Other _____
9. What is the highest grade you completed in school? (circle one)
   0 1 2 3 4 5 6 7 6 9 10 11 12 13 14 15 16 more then 16
10. For how many children are you seeking aid? (circle one)
    0 1 2 3 4 5 6 7 8 9 10 11 12 more then 12
11. How old is your oldest child? (circle one, unborn = 0)
    0 1 2 3 4 5 6 7 6 9 10 11 12 13 14 15 16 17 16 19 more then 19
12. If you have more then one child, how old is the youngest? (circle one, unborn = 0)
    0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 16 19 more then 19

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUR YOUR HEALTH CARE:

13. Do you have a regular source of health care now? 1) ☐ Yes 2) ☐ No
14. If you or a member of your household is sick, where do you usually go for care? 1) ☐ Private Doctor 2) ☐ County Clinic 3) ☐ County Hospital 4) ☐ Emergency Room 5) ☐ HMO/PHP 6) ☐ Other _____
15. Do you or any of the persons for whom you are seeking aid need medical care now? 1) ☐ Yes 2) ☐ No
16. Have you ever heard of Health Maintenance Organizations ; (HMOs/PHPs) before? 1) ☐ Yes 2) ☐ Not Sure 3) ☐ No
17. Have you or someone in your family ever belonged to a HMO/PHP before? . . . . 1) ☐ Yes 2) ☐ Not Sure

Appendix D: Data Collection Forms
Item 2a
Choice and Presentation Form for Medi-Cal Benefits - Contra Costa County

State of California—Health and Welfare Agency — Department of Health Services

CHOICE AND PRESENTATION INFORMATION FORM
FOR MEDI-CAL BENEFITS

See Reverse For Privacy Information Practices Act Notification

DIRECTIONS: *Please fill in the following information about your health care decision. REMEMBER, a choice should be made for each member of the family for whom you are applying. If you choose to enroll in a Medi-Cal Health Maintenance Organization (HMO/PHP), check the box labeled HMO.*
If you choose a Medi-Cal monthly sticker card, check the box labeled CARD.

TO THE STATE DEPARTMENT OF HEALTH SERVICES: I have made a choice between receiving a Medi-Cal monthly sticker card and enrolling in a Medi-Cal Health Maintenance Organization (HMO/PHP). If I (we) are eligible for Medi-Cal, I wish to receive health care benefits for myself and the family members for whom I am authorized to sign as I have indicated in the box below:

1. NAME (Please Print) Last	First	Middle	2. Relation To You:	3. Decision Check One: HMO	CARD	4. MEDI-CAL NUMBER	5. BIRTHDATE Mo. Day Year	6. SEX M=Male F=Female
A.			Self					
B.								
C.								
D.								
E.								
F.								
G.								

IF YOU HAVE CHOSEN AN HMO/PHP, CHECK THE BOX BY THE PLAN'S NAME AND TELL US HOW YOU WANT TO BE CONTACTED:

7. ☐ Contra Costa Key Plan

8. Contact me . . . . . 1) ☐ At home
2) ☐ By phone

9. Do you have any other Health Insurance? 1) ☐ Yes 2) ☐ No
Company: _____

PLEASE ANSWER THESE QUESTIONS ABOUT YOUR DECISION:

10. Was your decision the same for all members of your family? . . . . . 1) ☐ Yes 2) ☐ No

If you marked no, why was it different for some members?

_____

11. In making your decision, did you think health care in an HMO/PHP would be . . . .
Better than what you receive now . . . . . 1) ☐
About the same as you receive now . . . . . 2) ☐
Not as good as you receive now . . . . . 3) ☐

PRINT YOUR NAME AND ADDRESS BELOW:

Last	First	Middle	Street Number	Street/Road	City
Start Home		Date	City/Zip	Zip	Phone Number

COUNTY/PROJECT USE ONLY BELOW THIS LINE

1. Office (Site Location):
   1) ☐ Pittsburg 2) ☐ Richmond
   3) ☐ Oakland 4) ☐ Sacramento Co.
   5) ☐ East Valley 6) ☐ Florence
   7) ☐ Orange 8) ☐

2A. Type of Case:
   1) ☐ Intake 2) ☐ Re-evaluation
   3) ☐ Aid Code Change 4) ☐ Other

2B. Family Case Number: _____

3. Has client received aid in the last 6 months?
   1) ☐ Yes 2) ☐ No

4A. Was printed material received by client?
   1) ☐ In Advance 2) ☐ Day of Presentation

4B. Did client report reading the material?
   1) ☐ Yes 2) ☐ No

5. Did the client require a translator to understand the written or oral presentations?
   1) ☐ Yes 2) ☐ No

6. Date of Presentation: ___ ___ / ___ ___ / ___ ___
   Mo. Day Year

7. Presentation Setting:
   1) ☐ Individual Presentation
   2) ☐ Group 3) ☐ Couple 4) ☐ Other

8. Type of Presentation:
   1) ☐ Printed Material 2) ☐ EW
   3) ☐ HMO Rep 4) ☐ A-V (Film)
   5) ☐ State Worker 6) ☐ None
   If none, explain: _____

ITEMS 9–13, COUNTY, STATE, HMO REP PRESENTATIONS ONLY:

9. Presentation Started _____ : _____ am pm

10. Presentation Ended _____ : _____ am pm

11. Total Presentation Time (In Min.) ..... ___ ___ ___

12. Total County EW Time (In Min.) ..... ___ ___ ___

13. Total County Clerical Time ..... ___ ___ ___

14. Presentation made by: _____

MC 736 10/70

Appendix D: Data Collection Forms
Item 2a
Choice and Presentation Form for Medi-Cal Benefits - Northeast Valley (Los Angeles County)

State of California—[illegible]

CHOICE AND PRESENTATION INFORMATION FORM
FOR MEDI-CAL BENEFITS

See Reverse For Privacy Information Practice Act Notification

DIRECTIONS: *Please fill in the following information about your health care decision. REMEMBER, a choice should be made for each member of the family for whom you are applying. If you choose to enroll in a Medi-Cal Health Maintenance Organization (HMO/PHP), check the box labeled HMO.*
If you choose a Medi-Cal monthly sticker card, check the box labeled CARD.

| | | |

COUNTY/PROJECT USE ONLY BELOW THIS LINE

1. Office (Site Location):
   1) ☐ Pittsburg 2) ☐ Richmond
   3) ☐ Oakland 4) ☐ Sacramento Co.
   5) ☐ East Valley 6) ☐ Florence
   7) ☐ Orange 8) ☐

2A. Type of Case:
   1) ☐ Intake 2) ☐ Re-evaluation
   3) ☐ Aid Code Change 4) ☐ Other

2B. Family Case Number: _____

3. Has client received aid in the last 6 months?
   1) ☐ Yes 2) ☐ No

4A. Was printed material received by client?
   1) ☐ In Advance 2) ☐ Day of Presentation

4B. Did client report reading the material?
   1) ☐ Yes 2) ☐ No

5. Did the client require a translator to understand the written or oral presentations?
   1) ☐ Yes 2) ☐ No

6. Date of Presentation: ___ ___ / ___ ___ / ___ ___
   Mth. Day Year

7. Presentation Setting:
   1) ☐ Individual Presentation
   2) ☐ Group 3) ☐ Couple 4) ☐ Other

8. Type of Presentation:
   1) ☐ Printed Material 2) ☐ EW
   3) ☐ HMO Rep 4) ☐ A-V (Film)
   5) ☐ State Worker 6) ☐ None
   If none, explain: _____

ITEMS 9–13, COUNTY, STATE, HMO REP PRESENTATIONS ONLY:

9. Presentation Started _____ : _____ am pm

10. Presentation Ended _____ : _____ am pm

11. Total Presentation Time (In Min.) ..... ___ ___

12. Total County EW Time (In Min.) ..... ___ ___

13. Total County Clerical Time ..... ___ ___

14. Presentation made by: _____

Appendix D: Data Collection Forms
Item 2a
Choice and Presentation Form for Medi-Cal Benefits - Florence (Los Angeles County)

State of California—Health and Welfare Agency

Department of Health Services

CHOICE AND PRESENTATION INFORMATION FORM FOR MEDI-CAL BENEFITS

See Reverse For Privacy Information Practice Act Notification

DIRECTIONS: *Please fill in the following information about your health care decision. REMEMBER, a choice should be made for each member of the family for whom you are applying. If you choose to enroll in a Medi-Cal Health Maintenance Organization (HMO/PHP), check the box labeled HMO.*
If you choose a Medi-Cal monthly sticker card, check the box labeled CARD.

TO THE STATE DEPARTMENT OF HEALTH SERVICES: I have made a choice between receiving a Medi-Cal monthly sticker card and enrolling in a Medi-Cal Health Maintenance Organization (HMO/PHP). If I (we) are eligible for Medi-Cal, I wish to receive health care benefits for myself and the family members for whom I am authorized to sign as I have indicated in the box below:

1. NAME (Please Print) Last / First / Middle	2. Reason To You:	3. Decision (Check One) HMO	3. Decision (Check One) CARD	4. MEDI-CAL NUMBER	5. BIRTHDATE Mo. Day Year	6. SEX (Female or Male)
A.	Self					
B.						
C.						
D.						
E.						
F.						
G.						

IF YOU HAVE CHOSEN AN HMO/PHP, CHECK THE BOX BY THE PLAN'S NAME AND TELL US HOW YOU WANT TO BE CONTACTED:

7. ☐ California Medical Group ☐ CompreCare ☐ Kaiser ☐ Watts Health Plan

8. Contact me ..... 1) ☐ At home 2) ☐ By phone

9. Do you have any other Health Insurance? 1) ☐ Yes 2) ☐ No
Company: _____

PLEASE ANSWER THESE QUESTIONS ABOUT YOUR DECISION:

10. Was your decision the same for all members of your family? ..... 1) ☐ Yes 2) ☐ No

If you marked no, why was it different for some members?

_____

11. In making your decision, did you think health care in an HMO/PHP would be ....
Better than what you receive now ..... 1) ☐
About the same as you receive now ..... 2) ☐
Not as good as you receive now ..... 3) ☐

PRINT YOUR NAME AND ADDRESS BELOW:

Last / First / Middle _____ Street Number / Street/Road / City _____

Sex: Male/Female _____ Date _____ County _____ Zip _____ Phone Number _____

COUNTY/PROJECT USE ONLY BELOW THIS LINE

1. Office (Site Location):
   1) ☐ Pittsburg 2) ☐ Richmond
   3) ☐ Oakland 4) ☐ Sacramento Co.
   5) ☐ East Valley 6) ☐ Florence
   7) ☐ Orange 8) ☐

2A. Type of Case:
   1) ☐ Intake 2) ☐ Re-evaluation
   3) ☐ Aid Code Change 4) ☐ Other

2B. Family Case Number: _____

3. Has client received aid in the last 6 months?
   1) ☐ Yes 2) ☐ No

4A. Was printed material received by client?
   1) ☐ In Advance 2) ☐ Day of Presentation

4B. Did client report reading the material?
   1) ☐ Yes 2) ☐ No

5. Did the client require a translator to understand the written or oral presentations?
   1) ☐ Yes 2) ☐ No

6. Date of Presentation: . ___ ___ ___ ___ ___ ___
   Mo. Day Year

7. Presentation Setting:
   1) ☐ Individual Presentation
   2) ☐ Group 3) ☐ Couple 4) ☐ Other

8. Type of Presentation:
   1) ☐ Printed Material 2) ☐ EW
   3) ☐ HMO Rep 4) ☐ A-V (Film)
   5) ☐ State Worker 6) ☐ None
   If none, explain: _____

ITEMS 9–13, COUNTY, STATE, HMO REP PRESENTATIONS ONLY:

9. Presentation Started _____ : _____ am pm

10. Presentation Ended _____ : _____ am pm

11. Total Presentation Time (In Min.) ..... ___ ___ ___

12. Total County EW Time (In Min.) ..... ___ ___ ___

13. Total County Clerical Time ..... ___ ___ ___

14. Presentation made by: _____

MC 7260 (4/79)

State of California—Health and Welfare Agency

Department of Health Services

CHOICE AND PRESENTATION INFORMATION FORM FOR MEDI-CAL BENEFITS

See Reverse For Privacy Information Practices Act Notification

DIRECTIONS: *Please fill in the following information about your health care decision. REMEMBER, a choice should be made for each member of the family for whom you are applying. If you choose to enroll in a Medi-Cal Health Maintenance Organization (HMO/PHP), check the box labeled HMO.*
If you choose a Medi-Cal monthly sticker card, check the box labeled CARD.

1c

TO THE STATE DEPARTMENT OF HEALTH SERVICES: I have made a choice between receiving a Medi-Cal monthly sticker card and enrolling in a Medi-Cal Health Maintenance Organization (HMO/PHP). If I (we) are eligible for Medi-Cal, I wish to receive health care benefits for myself and the family members for whom I am authorized to sign as I have indicated in the box below:

1. NAME (Please Print) Last	First	Middle	3. Relation To You:	5. Decision Check One HMO	CARD	4. MEDI-CAL NUMBER	6. BIRTHDATE Mo. Day Year	7. SEX F=Female M=Male
A.			Self					
B.								
C.								
D.								
E.								
F.								
G.								

IF YOU HAVE CHOSEN AN HMO/PHP, CHECK THE BOX BY THE PLAN'S NAME AND TELL US HOW YOU WANT TO BE CONTACTED:

7. ☐ Rockridge

8. Contact me ..... 1) ☐ At home
2) ☐ By phone

9. Do you have any other Health Insurance? 1) ☐ Yes 2) ☐ No
Company: _____

PLEASE ANSWER THESE QUESTIONS ABOUT YOUR DECISION:

10. Was your decision the same for all members of your family? ..... 1) ☐ Yes 2) ☐ No

If you marked no, why was it different for some members?

_____

11. In making your decision, did you think health care in an HMO/PHP would be ....
Better than what you receive now ..... 1) ☐
About the same as you receive now ..... 2) ☐
Not as good as you receive now ..... 3) ☐

PRINT YOUR NAME AND ADDRESS BELOW:

Last	First	Middle Initial	Street Number	Street/Road	City
Your Name		Date	County	Zip	Phone Number

COUNTY/PROJECT USE ONLY BELOW THIS LINE

1. Office (City Location):
   1) ☐ Pittsburg 2) ☐ Richmond
   3) ☐ Oakland 4) ☐ Sacramento Co.
   5) ☐ East Valley 6) ☐ Florence
   7) ☐ Orange 8) ☐

2A. Type of Case:
   1) ☐ Intake 2) ☐ Re-evaluation
   3) ☐ Aid Code Change 4) ☐ Other

2B. Family Case Number: _____

3. Has client received aid in the last 6 months?
   1) ☐ Yes 2) ☐ No

4A. Was printed material received by client?
   1) ☐ In Advance 2) ☐ Day of Presentation

4B. Did client report reading the material?
   1) ☐ Yes 2) ☐ No

5. Did the client require a translator to understand the written or oral presentations?
   1) ☐ Yes 2) ☐ No

6. Date of Presentation: |_|_| |_|_| |_|_|
   Mth. Day Year

7. Presentation Setting:
   1) ☐ Individual Presentation
   2) ☐ Group 3) ☐ Couple 4) ☐ Other

8. Type of Presentation:
   1) ☐ Printed Material 2) ☐ EW
   3) ☐ HMO Rep 4) ☐ AV (Film)
   5) ☐ State Worker 6) ☐ None
   If none, explain: _____

ITEMS 9–13, COUNTY, STATE, HMO REP PRESENTATIONS ONLY:

9. Presentation Started _____ : _____ am pm

10. Presentation Ended _____ : _____ am pm

11. Total Presentation Time (In Min.) ..... |_|_|_|

12. Total County EW Time (In Min.) ..... |_|_|_|

13. Total County Clerical Time ..... |_|_|_|

14. Presentation made by: _____

MC 738A (4/79)

Item 2a

Copy of Sacramento Site Choice Form Unavailable

Appendix O: Data Collection Forms
Item 2D
Mail Choice Card - Orange County
English Version

Please take a few minutes to answer these questions:

1. Do you usually go to the same place for health care?
   1) ☐ Yes 2) ☐ No
2. If you or a member of your household is sick, where do you go for care?
   1) ☐ Private doctor 2) ☐ County clinic
   3) ☐ County hospital 4) ☐ Emergency room
   5) ☐ Other _____
3. Do you or a member of your household need medical care now? 1) ☐ Yes 2) ☐ No
4. Had you ever heard of Health Maintenance Organizations (HMOs) or PHPs before you received this?
   1) ☐ Yes 2) ☐ No
5. Have you or a member of your family ever joined an HMO or PHP? 1) ☐ Yes 2) ☐ No

Mail back to State Dept. of Health Services — No stamp necessary

(Véase el otro lado para la versión en español)

- Please tell us what you have decided about your health care by marking:
  Box A — Enroll me and in an HMO.
  Box B — I'd like to learn more about HMOs, but keep my sticker card for now.
  Box C — I'd like to keep my monthly sticker card.

- If you have checked box A or B (HMO), check the box by the health plan's name below and tell us how you want to be contacted.

☐ California Medical Group

☐ Kaiser

☐ Home Visit ☐ Telephone Call ☐ Mail

Here is the choice: (Please give choice below for all other family members in your household.)

Name Last, First, Middle	Relationship to You?	Sex	Birthdate Mo/Day/Yr	A Enroll in An HMO?	B Learn More About HMOs?	C Monthly Sticker Card?

Print Name	Sign	Date	Phone (Area Code)

Appendix D: Data Collection Forms
Item 2c
Spanish Version

Por favor tómese unos minutos para contestar estas preguntas.

1. ¿Tiene usted un médico de recibir cuidados para la salud regularmente? 1) ☐ Sí 2) ☐ No
2. ¿Si usted o una persona de su casa se enferma, a dónde va, generalmente, por atención médica? 1) Médico privado 2) Clínica del condado 3) Hospital del condado 4) Servicio de emergencia 5) otro._____
3. ¿Usted o una persona de su casa necesita cuidados médicos ahora? 1) ☐ Sí 2) ☐ No
4. ¿Sabía ya de las Organizaciones para el Mantenimiento de la Salud (HMOs) o PHPs antes de haber recibido ésta? 1) ☐ Sí 2) ☐ No
5. ¿Nunca ha ingresado, usted o un miembro de su familia, a un HMO o PHP? 1) ☐ Sí 2) ☐ No

---

• Por favor díganos que ha decidido acerca de los cuidados para su salud, marcando

Cuadro A — Enrolé me en un HMO.

Cuadro B — Deseo tener más información acerca de un HMO. Por ahora me quedaré con mi tarjeta con etiquetas

Cuadro C — Deseo quedarme con mi tarjeta con etiquetas mensualmente.

• Si usted ha escogido cuadros A or B (HMO), marque el cuadro con el nombre del plan y díganos como comunicarnos con usted.

☐ California Medical Group

☐ Kaiser

☐ ¿Visita en su casa? ☐ ¿Llamada teléfonica? ☐ ¿Por correo?

Regrésela al Departamento de Servicios de Salud del Estado — No necesita estampilla

Esto es lo que escogí: (Por favor dé la preferencia correspondiente por cada miembro de la familia en su casa.)

Nombre: Apellido, Primero, Segundo	¿Qué Relación a Ud.?	Sexo	Fecha de Nacimiento Mes, Día, Año	A Enrole en HMO	B Deseo más información	C Quedaré la tarjeta

Nombre ___ ___ ___ ___ ___
(letra de imprenta) Dirección Ciudad Zona Postal (Codigo la area) Teléfono

Firma. ___ Fecha: ___ Número de Medi-Cal. ___ ___ ___
(Favor de copiar los números en el lado izquierdo de su tarjeta, hasta las estrellitas**)

Appendix D: Data Collection Forms
Item 2b
Mail Choice Card - Health Care
(Sacramento County) English Version

Please take a few minutes to answer these questions:

1. Do you have a regular source of health care?
   1) ☐ Yes 2) ☐ No
2. If you or a member of your household is sick, where do you usually go for care?
   1) ☐ Private doctor 2) ☐ County clinic
   3) ☐ County hospital 4) ☐ Emergency room
   5) ☐ (Other)
3. Do you or a member of your household need medical care now? 1) ☐ Yes 2) ☐ No
4. Had you ever heard of Health Maintenance Organizations (HMOs) before you received this?
   1) ☐ Yes 2) ☐ No
5. Have you or a member of your family ever joined an HMO? 1) ☐ Yes 2) ☐ No

Mail back to State Dept. of Health Services — No stamp necessary

(Vease el otro lado para la version en espanol)

- Please tell us what you have decided about your health care by marking:
  - Box A — Enroll me and my family in an HMO
  - Box B — I'd like to learn more about HMOs, but keep my sticker card for now.
  - Box C — I'd like to keep my monthly sticker card.

- If you have chosen an HMO, check the box by the plan's name below and tell us how you want to be contacted:

☐ Home Visit ☐ Telephone Call

☐ Healthcare

Here is the choice: (Please give information below for each family member, including yourself.)

Name Last First Middle	Relationship to You?	Sex	Birthday Mo./Day/Yr.	A Enroll in An HMO	B Learn More About HMOs	C Monthly Sticker Card
	(Self)					

Print Name	Sign	Date	Phone

Appendix D: Data Collection Forms
Item 2b
Mail Choice Card - Health Care
(Sacramento County) Spanish Version

Por favor tómese unos minutos para contestar estas preguntas:

1. ¿Tiene usted un médico de recibir cuidados para la salud regularmente? 1) ☐ Sí 2) ☐ No
2. ¿Si usted o una persona de su casa se enferma, a dónde va, generalmente, por atención médica?
   1) Médico privado 2) Clínica del condado
   3) Hospital del condado 4) Servicio de emergencia 5) otro
3. ¿Usted o una persona de su casa necesita cuidados médicos ahora? 1) ☐ Sí 2) ☐ No
4. ¿Sabía ya de las Organizaciones para el Mantenimiento de la Salud (HMOs) antes de haber recibido ésta? 1) ☐ Sí 2) ☐ No
5. ¿Nunca ha ingresado, usted o un miembro de su familia, a un HMO? 1) ☐ Sí 2) ☐ No

---

- Por favor díganos que ha decidido acerca de los cuidados para su salud, marcando:

  Cuadro A — Enrolen a mi familia y a mí en un HMO.

  Cuadro B — Deseo tener más información acerca de un HMO. Por ahora me quedaré con mi tarjeta con etiquetas.

  Cuadro C — Deseo quedarme con mi tarjeta con etiquetas mensualmente.

- Si usted ha escogido un HMO, marque el cuadro con el nombre del plan y díganos cómo comunicarnos con usted.

  ☐ ¿Visita en su casa? ☐ ¿Llamada telefónica?

  ☐ Grupo de Plan de Servicios para la Salud "Healthcare"

Regrese la al Departamento de Servicios de Salud del Estado — No necesita estampilla.

Esto es lo que escogí: (Por favor dé la información correspondiente por cada miembro de la familia, incluyéndose usted mismo)

Nombre Apellido Primero Segundo	¿Qué Relación a Ud.?	Sexo	Fecha de Nacimiento Mes Día Año	A Enrolme en un HMO	B Deseo más información	C Guardaré mi tarjeta

Nombre: _____
(letra de imprenta) Dirección Ciudad Zona Postal Teléfono

Firma: _____ Fecha: ____ ___Número de Medi-Cal _____
(Favor de copiar los números en el lado izquierdo de su tarjeta, hasta las estrellitas**)

Appendix D: Data Collection Forms
Item 2b
Mail Choice Card - Contra Costa County Key Plan (Contra Costa County) English Version

Please take a few minutes to answer these questions.

1. Do you have a regular source of health care?
   1) ☐ Yes 2) ☐ No
2. If you or a member of your household is sick, where do you usually go for care?
   1) ☐ Private doctor 2) ☐ County clinic
   3) ☐ County hospital 4) ☐ Emergency room
   5) ☐ Other
3. Do you or a member of your household need medical care now? 1) ☐ Yes 2) ☐ No
4. Had you ever heard of Health Maintenance Organizations (HMOs) before you received this? 1) ☐ Yes 2) ☐ No
5. Have you or a member of your family ever joined an HMO? 1) ☐ Yes 2) ☐ No

Mail back to State Dept. of Health Services — No stamp necessary

(Vease el otro lado para la version en espanol)

* Please tell us what you have decided about your health care by marking
  Box A — Enroll me and my family in an HMO.
  Box B — I'd like to learn more about HMOs, but keep my sticker card for now.
  Box C — I'd like to keep my monthly sticker card.

* If you have chosen an HMO, check the box by the plan's name below and tell us how you want to be contacted.

☐ Home Visit ☐ Telephone Call

☐ Contra Costa Key Plan

Here is the choice. (Please give information below for each family member, including yourself.)

Name Last First Middle	Relationship to You (self)	Sex	Birthday Mo Day Yr	A Enroll in an HMO	B Learn More About HMOs	C Monthly Sticker Card

Print Name	Sign	Date	Phone

Appendix D: Data Collection Forms
Item 2b
Spanish Version

Por favor tómese unos minutos para contestar estas preguntas.

1. ¿Tiene usted un médico de recibir cuidados para la salud regularmente? 1) ☐ Sí 2) ☐ No
2. ¿Si usted o una persona de su casa se enferma, a dónde va, generalmente, por atención médica? 1) Médico privado 2) Clínica del condado 3) Hospital del condado 4) Servicio de emergencia 5) otro
3. ¿Usted o una persona de su casa necesita cuidados médicos ahora? 1) ☐ Sí 2) ☐ No
4. ¿Sabía ya de las Organizaciones para el Mantenimiento de la Salud (HMOs) antes de haber recibido ésta? 1) ☐ Sí 2) ☐ No
5. ¿Nunca ha ingresado, usted o un miembro de su familia, a un HMO? 1) ☐ Sí 2) ☐ No

---

- Por favor díganos que ha decidido acerca de los cuidados para su salud, marcando:

  Cuadro A — Enrolen a mi familia y a mí en un HMO.

  Cuadro B — Deseo tener más información acerca de un HMO. Por ahora me quedaré con mi tarjeta con etiquetas

  Cuadro C — Deseo quedarme con mi tarjeta con etiquetas mensualmente

- Si usted ha escogido un HMO, marque el cuadro con el nombre del plan y díganos cómo comunicarnos con usted

  ☐ ¿Visita en su casa? ☐ ¿Llamada telefónica?

  ☐ El Plan Llave del Condado De Contra Costa

Regréselo al Departamento de Servicios de Salud del Estado — No necesita estampilla.

Esto es lo que escogí (Por favor de la información correspondiente por cada miembro de la familia, incluyendose usted mismo)

Nombre Apellido Primero Segundo	¿Qué Relación a Ud.?	Sexo	Fecha de Nacimiento Mes-Día-Año	A Entrarme en un HMO?	B Deseo más información	C Guardaré mi tarjeta

Nombre: _____
(letra de imprenta) Dirección Ciudad Zona Postal Teléfono

Firma: _____ Fecha: _____ Número de Medi-Cal: _____

(Favor de copiar los números en el lado izquierdo de su tarjeta, hasta las estrellitas**)

Appendix D: Data Collection Forms
Item 2b
Mail Choice Card - Orange County
English Version

Please take a few minutes to answer these questions:

1. Do you usually go to the same place for health care?
   1) ☐ Yes 2) ☐ No
2. If you or a member of your household is sick, where do you go for care?
   1) ☐ Private doctor 2) ☐ County clinic
   3) ☐ County hospital 4) ☐ Emergency room
   5) ☐ Other _____
3. Do you or a member of your household need medical care now? 1) ☐ Yes 2) ☐ No
4. Had you ever heard of Health Maintenance Organizations (HMOs) or PHPs before you received this?
   1) ☐ Yes 2) ☐ No
5. Have you or a member of your family ever joined an HMO or PHP? 1) ☐ Yes 2) ☐ No

Mail back to State Dept. of Health Services — No stamp necessary

(Véase el otro lado para la versión en español)

- Please tell us what you have decided about your health care by marking:
  Box A — Enroll me and in an HMO.
  Box B — I'd like to learn more about HMOs, but keep my sticker card for now.
  Box C — I'd like to keep my monthly sticker card.

- If you have checked box A or B (HMO), check the box by the health plan's name below and tell us how you want to be contacted.

☐ California Medical Group
☐ Kaiser
☐ Home Visit ☐ Telephone Call ☐ Mail

Here is the choice: (Please give choice below for all other family members in your household.)

Name: Last, First, Middle	Relationship to You?	Sex	Birthdate Mo/Day/Yr	A Enroll in An HMO?	B Learn More About HMOs?	C Monthly Sticker Card?

Print Name	Sign	Date	Phone (Area Code)

Appendix D: Data Collection Forms
Item 2b
Spanish Version

Por favor tómese unos minutos para contestar estas preguntas.

1. ¿Tiene usted un médico de recibir cuidados para la salud regularmente? 1) ☐ Sí 2) ☐ No
2. ¿Si usted o una persona de su casa se enferma, a dónde va, generalmente, por atención médica? 1) Médico privado 2) Clínica del condado 3) Hospital del condado 4) Servicio de emergencia 5) otro._____
3. ¿Usted o una persona de su casa necesita cuidados médicos ahora? 1) ☐ Sí 2) ☐ No
4. ¿Sabía ya de las Organizaciones para el Mantenimiento de la Salud (HMOs) o PHPs antes de haber recibido ésta? 1) ☐ Sí 2) ☐ No
5. ¿Nunca ha ingresado, usted o un miembro de su familia, a un HMO o PHP? 1) ☐ Sí 2) ☐ No

---

- Por favor díganos que ha decidido acerca de los cuidados para su salud, marcando:

  Cuadro A — Enrolé me en un HMO.

  Cuadro B — Deseo tener más información acerca de un HMO. Por ahora me quedaré con mi tarjeta con etiquetas

  Cuadro C — Deseo quedarme con mi tarjeta con etiquetas mensualmente

- Si usted ha escogido cuadros A or B (HMO), marque el cuadro con el nombre del plan y díganos como comunicarnos con usted.

  ☐ California Medical Group

  [redacted]

  ☐ Kaiser

  ☐ ¿Visita en su casa? ☐ ¿Llamada telefónica? ☐ ¿Por correo?

Regrésela al Departamento de Servicios de Salud del Estado — No necesita estampilla

Esto es lo que escogí: (Por favor dé la preferencia correspondiente por cada miembro de la familia en su casa.)

Nombre Apellido Primero Segundo	¿Que Relacion a Ud.?	Sexo	Fecha de Nacimiento Mes Dia Año	A Enrole en HMO	B Deseo más información	C Guardaré la tarjeta

Nombre: _____
(letra de imprenta) Dirección _____ Ciudad _____ Zona Postal _____ (Codigo la area) Teléfono _____

Firma _____ Fecha _____ Número de Medi-Cal _____

(Favor de copiar los números en el lado izquierdo de su tarjeta, hasta las estrellitas "*")

Appendix D: Data Collection Forms
Item 2b
Mail Choice Card - Rockridge
(Alameda County) English Version

Please take a few minutes to answer these questions:

1. Do you have a regular source of health care?
   1) ☐ Yes 2) ☐ No
2. If you or a member of your household is sick, where do you usually go for care?
   1) ☐ Private doctor 2) ☐ County clinic
   3) ☐ County hospital 4) ☐ Emergency room
   5) ☐ Other
3. Do you or a member of your household need medical care now? 1) ☐ Yes 2) ☐ No
4. Had you ever heard of Health Maintenance Organizations (HMOs) before you received this?
   1) ☐ Yes 2) ☐ No
5. Have you or a member of your family ever joined an HMO? 1) ☐ Yes 2) ☐ No

Mail back to State Dept of Health Services — No stamp necessary

(Vease el otro lado para la version en espanol)

- Please tell us what you have decided about your health care by marking.
  - Box A — Enroll me and my family in an HMO.
  - Box B — I'd like to learn more about HMOs, but keep my sticker card for now.
  - Box C — I'd like to keep my monthly sticker card.

- If you have chosen an HMO, check the box by the plan's name below and tell us how you want to be contacted
  - ☐ Home Visit ☐ Telephone Call
  - ☐ Rockridge

Here is the choice. (Please give information below for each family member, including yourself.)

Name Last First Middle	Relationship to You?	Sex	Birthday Mo. Day Yr	A Enroll Me in HMO	B Learn More About HMOs	C Monthly Sticker Card
	Self					

Print Name	Sign	Date	Phone

Por favor tómese unos minutos para contestar estas preguntas.

1. ¿Tiene usted un médico de recibir cuidados para la salud regularmente? 1) ☐ Sí 2) ☐ No
2. ¿Si usted o una persona de su casa se enferma, a dónde va, generalmente, por atención médica? 1) Médico privado 2) Clínica del condado 3) Hospital del condado 4) Servicio de emergencia 5) otro
3. ¿Usted o una persona de su casa necesita cuidados médicos ahora?1) ☐ Sí 2) ☐ No
4. ¿Sabía ya de las Organizaciones para el Mantenimiento de la Salud (HMOs) antes de haber recibido ésta? 1) ☐ Sí 2) ☐ No
5. ¿Nunca ha ingresado usted o un miembro de su familia, a un HMO? 1) ☐ Sí 2) ☐ No

• Por favor díganos que ha decidido acerca de los cuidados para su salud, marcando:

Cuadro A — Enrolen a mi familia y a mí en un HMO

Cuadro B — Deseo tener más información acerca de un HMO. Por ahora me quedaré con mi tarjeta con etiquetas

Cuadro C — Deseo quedarme con mi tarjeta con etiquetas mensualmente

• Si usted ha escogido un HMO, marque el cuadro con el nombre del plan y díganos cómo comunicarnos con usted

☐ ¿Visita en su casa? ☐ ¿Llamada telefónica?

☐ "Rockridge" Plan de Ciudados para la Salud

Regrésela al Departamento de Servicios de Salud del Estado — No necesita estampilla

Esto es lo que escogí (Por favor de la información correspondiente por cada miembro de la familia, incluyendose usted mismo)

Nombre: Apellido, Primero, Segundo	¿Qué Relación a usted?	Sexo	Fecha de Nacimiento Mes, Día, Año	A Empleo en un HMO	B Deseo más información	C Guardaré mi tarjeta

Nombre: _____

(letra de imprenta) Dirección Ciudad Zona Postal Teléfono

Firma. Fecha: Número de Medi-Cal

(Favor de copiar los números en el lado izquierdo de su tarjeta hasta las letras)

Appendix D: Data Collection Forms
Item 2b
Mail Choice Card - Northeast Valley (Los Angeles County) English Version

Please take a few minutes to answer these questions.

1. Do you have a regular source of health care?
   1) ☐ Yes 2) ☐ No
2. If you or a member of your household is sick, where do you usually go for care?
   1) ☐ Private doctor 2) ☐ County clinic
   3) ☐ County hospital 4) ☐ Emergency room
   5) ☐ Other
3. Do you or a member of your household need medical care now? 1) ☐ Yes 2) ☐ No
4. Had you ever heard of Health Maintenance Organizations (HMOs) before you received this?
   1) ☐ Yes 2) ☐ No
5. Have you or a member of your family ever joined an HMO? 1) ☐ Yes 2) ☐ No

Mail back to State Dept. of Health Services — No stamp necessary

(Vease el otro lado para la version en espanol)

- Please tell us what you have decided about your health care by marking:
  Box A — Enroll me and my family in an HMO.
  Box B — I'd like to learn more about HMOs, but keep my sticker card for now.
  Box C — I'd like to keep my monthly sticker card.

- If you have chosen an HMO, check the box by the plan's name below and tell us how you want to be contacted.
  ☐ Home Visit ☐ Telephone Call
  ☐ California Medical Group
  ☐ HMO Concepts
  ☐ Kaiser

Here is the choice: (Please give information below for each family member, including yourself.)

Name Last First Middle	Relationship to You? (self)	Sex	Birthday Mo. Day Yr.	A Enroll in An HMO	B Learn More About HMOs	C Monthly Sticker Card

Print Name	Sign	Date	Phone

Por favor tómese unos minutos para contestar estas preguntas:

1. ¿Tiene usted un médico de recibir cuidados para la salud regularmente? 1) ☐ Sí 2) ☐ No
2. ¿Si usted o una persona de su casa se enferma, a dónde va, generalmente, por atención médica?
   1) Médico privado 2) Clínica del condado
   3) Hospital del condado 4) Servicio de emergencia 5) otro
3. ¿Usted o una persona de su casa necesita cuidados médicos ahora? 1) ☐ Sí 2) ☐ No
4. ¿Sabía ya de las Organizaciones para el Mantenimiento de la Salud (HMOs) antes de haber recibido ésta? 1) ☐ Sí 2) ☐ No
5. ¿Nunca ha ingresado, usted o un miembro de su familia, a un HMO? 1) ☐ Sí 2) ☐ No

---

- Por favor díganos que ha decidido acerca de los cuidados para su salud, marcando.

  Cuadro A — Enrolen a mi familia y a mí en un HMO

  Cuadro B — Deseo tener más información acerca de un HMO. Por ahora me quedaré con mi tarjeta con etiquetas

  Cuadro C — Deseo quedarme con mi tarjeta con etiquetas mensualmente.

- Si usted ha escogido un HMO, marque el cuadro con el nombre del plan y díganos cómo comunicarnos con usted

  ☐ ¿Visita en su casa? ☐ ¿Llamada telefónica?
  ☐ Grupo Médico California Plan de Salud
  ☐ Los Conceptos de HMO
  ☐ Fundación Kaiser Plan de Salud

Regréselo al Departamento de Servicios de Salud del Estado — No necesita estampilla.

Esto es lo que escogí (Por favor dé la información correspondiente por cada miembro de la familia, incluyendose usted mismo)

Nombre Apellido Primero Segundo	¿Qué Relación a Ud.?	Sexo	Fecha de Nacimiento Mes/Día/Año	A Escriba en "x" usted	B Deseo más información	C Guarde mi tarjeta

Nombre: _____
(letra de imprenta) Dirección Ciudad Zona Postal Teléfono

Firma: _____ Fecha: _____ Número de Medi-Cal _____

(Favor de copiar los números en el lado izquierdo de su tarjeta, hasta las estrellitas**)

Appendix D: Data Collection Forms
Item 2b
Mail Choice Card - Florence (Los Angeles County) English Version

Please take a few minutes to answer these questions:

1. Do you usually go to the same place for health care?
   1) ☐ Yes 2) ☐ No
2. If you or a member of your household is sick, where do you go for care?
   1) ☐ Private doctor 2) ☐ County clinic
   3) ☐ County hospital 4) ☐ Emergency room
   5) ☐ Other _____
3. Do you or a member of your household need medical care now? 1) ☐ Yes 2) ☐ No
4. Had you ever heard of Health Maintenance Organizations (HMOs) or PHPs before you received this? 1) ☐ Yes 2) ☐ No
5. Have you or a member of your family ever joined an HMO or PHP? 1) ☐ Yes 2) ☐ No

Mail back to State Dept. of Health Services — No stamp necessary.

(Véase el otro lado para la versión en español)

- Please tell us what you have decided about your health care by marking:
  Box A — Enroll me and in an HMO
  Box B — I'd like to learn more about HMOs, but keep my sticker card for now.
  Box C — I'd like to keep my monthly sticker card.

- If you have checked box A or B (HMO), check the box by the health plan's name below and tell us how you want to be contacted.

☐ Kaiser ☐ California Medical Group
☐ Watts ☐ Compre Care

☐ Home Visit ☐ Telephone Call ☐ Mail

Here is the choice: (Please give choice below for all other family members in your household.)

Name Last First Middle	Relationship to You?	Sex	Birthdate Mo/Day/Yr	A Enroll in An HMO?	B Learn More About HMOs?	C Monthly Doctor Card?

Print Name	Sign	Date	Phone (Area Code)

Por favor tómese unos minutos para contestar estas preguntas:

1. ¿Tiene usted un médico de recibir cuidados para la salud regularmente? 1) ☐ Sí 2) ☐ No
2. ¿Si usted o una persona de su casa se enferma, a dónde va, generalmente, por atención médica?
   1) Médico privado 2) Clínica del condado
   3) Hospital del condado 4) Servicio de emergencia 5) otro_____
3. ¿Usted o una persona de su casa necesita cuidados médicos ahora? 1) ☐ Sí 2) ☐ No
4. ¿Sabía ya de las Organizaciones para el Mantenimiento de la Salud (HMOs) o PHPs antes de haber recibido ésta? 1) ☐ Sí 2) ☐ No
5. ¿Nunca ha ingresado, usted o un miembro de su familia, a un HMO o PHP? 1) ☐ Sí 2) ☐ No

---

- Por favor díganos que ha decidido acerca de los cuidados para su salud, marcando:

  Cuadro A — Enrolé me en un HMO.

  Cuadro B — Deseo tener más información acerca de un HMO. Por ahora me quedaré con mi tarjeta con etiquetas.

  Cuadro C — Deseo quedarme con mi tarjeta con etiquetas mensualmente.

- Si usted ha escogido cuadros A or B (HMO), marque el cuadro con el nombre del plan y díganos como comunicarnos con usted.

  ☐ Kaiser ☐ California Medical Group
  ☐ Watts ☐ Compre Care

  ☐ ¿Visita en su casa? ☐ ¿Llamada teléfonica?
  ☐ ¿Por correo?

Regréselo al Departamento de Servicios de Salud del Estado — No necesita estampilla.

Esto es lo que escogí: (Por favor dé la preferencia correspondiente por cada miembro de la familia en su casa.)

Nombre Apellido Primero Segundo	¿Que Relacion a usted ?	Sexo	Fecha de Nacimiento Mes/Dia/Año	A Enrole en HMO	B Deseo más información	C Guardaré la tarjeta

Nombre:_____
(letra de imprenta) Dirección Ciudad Zona Postal (Codigo la area) Teléfono

Firma:_____ Fecha:_____Número de Medi-Cal:_____
(Favor de copiar los números en el lado izquierdo de su tarjeta, hasta las estreilitas**)

State of California—Health and Welfare Agency

PRESENTATION RESULTS REPORT

Department of Health Services

Name of Rep: Name of Plan: Method: Date:

(1) a. Street b. City	(2) Street Number	(3) Apt. Number	(4) Person Home? Y or/No	(5) a. Name of Person Contacted b. Medi-Cal Number	(6) Eligible for PHP Y or/No	(7) Name of PHP If Enrolled	(8) Presentation Made Y or/No	(9) Reason of Presentation Y or/No/N/A	(10) Number of Enrollments	(11) Number of Persons in Family	(12) Time Started (Ex: 12:15 P.M.)	(13) Time Ended (Ex: 12:30 P.M.)	(14) Time Spent (Ex: 010 Min.)	(15) a. Phone Number (If Available b. Notes (Explain Nos. in 8 & 9 and Discrepancy in 10 & 11)
a.				a.										a.
b.				b.										b.
a.				a.										a.
b.				b.										b.
a.				a.										a.
b.				b.										b.
a.				a.										a.
b.				b.										b.
a.				a.										a.
b.				b.										b.
a.				a.										a.
b.				b.										b.

Appendix D: Data Collection Forms
Presentation Results Report

MC 730 (12/79)

APPENDIX E

Instruction Manual, Data Collection Forms for Health Plans

The PHRED Project* membership studies will produce valuable and credible results only through the combined efforts of the Department of Health Services, the county welfare departments and the prepaid health plans which contract with the Department of Health Services to provide care to Medi-Cal beneficiaries. This manual is designed to serve as training and operating instructions for those plans participating in the PHRED Project membership demonstrations. The purpose of the manual is to familiarize the plans with their responsibilities in collecting and reporting data.

The manual is divided into four parts. Part I describes the plan's responsibilities during that period of the demonstrations in which current marketing methods are being evaluated. Part II describes how the plan is to process referrals obtained as a result of the mailing to be sent by DHS. Part III describes the data collection and reporting responsibilities of the plan during any period in which a welfare office method is being used. Part IV contains a schedule and listing of ZIP codes for the demonstration area(s).

*The Prepaid Health Research, Evaluation and Demonstration (PHRED) Project is supported by a grant from DHEW's Health Care Financing Administration (HCFA). The goal of the Project is to develop model administrative systems and procedures that can be used by any state which contracts with prepaid health plans for the care of Medicaid (Medi-Cal) beneficiaries.

State of California—Health and Welfare Agency

Appendix D: Data Collection Forms
Item 3a
Phone Follow-Up Information Form

Department of Health Services

F

PHONE FOLLOW-UP INFORMATION FORM (PFIF)

I
Completed ☐
Follow-Up ☐
II
Meiler ☐
Current ☐
In-Office ☐
III
Enrolled ☐
Not Enrolled ☐

(To be used to collect demographic, choice factor, comprehension, and verification data)

INSTRUCTIONS TO THE INTERVIEWER: Fill in as much information as possible before the contact. When using the probe/comment response, circle the appropriate category and write in phrase/question. Make sure that the proper sections are completed for each individual.

Medi-Cal Number _____ Phone _____-_____-_____

SECTION I – ALL PERSONS

Hello, is this Mrs. / Ms. / Mr. _____? My name is _____, I am with the Department of Health Services.

1. Recently you were contacted: ☐ 1) by mail ☐ 2) at home ☐ 3) at the Social Service office ☐ 4) Other _____ about joining a pre-paid health plan. You were asked to choose between a PHP and your regular Medi-Cal card. *Probe/Comment* _____ 1. _____

2. I have down here that you want to:
   ☐ A) Join e/ _____ PHP with _____ Other members of your family.
   Is this correct?
   ☐ 1) Yes, continue
   ☐ 2) No, *Probe/Comment* _____ 2A. _____

   ☐ B) Stay with regular Medi-Cal. Is this correct?
   ☐ 3) Yes, continue
   ☐ 4) No, *Probe/Comment* _____ 2B. _____

I would really appreciate it if you would take a few minutes and discuss your decision with me. The Department of Health Services is very interested in improving how health care is provided to you. One important way that we can do that is by getting your opinions.

3. Is this all right with you?
   ☐ 1) Yes, continue
   ☐ No, then *Probe: Is there some other time that I could call back that would be more convenient for you?*
   ☐ 2) Yes, take time and date: _____
   ☐ 3) No, thank respondent for time and say good-bye. 3. _____

SECTION II – MAIL RESPONDENTS ONLY

First, Mrs. / Ms. / Mr. _____, I'd like to ask you two questions about the mail packet that you received from the department.

4. What did you think you had to do when you got the mailing?
   ☐ 1) Enroll in a plan. ☐ 2) Get more information
   ☐ 3) Send back card to stay on Medi-Cal ☐ 4) Nothing ☐ 5) Other 4. _____

5. Did the mailing help you?
   ☐ 1) Yes, *Comment:* _____
   ☐ 2) No, *Comment:* _____
   ☐ 3) Other, *Comment:* _____ 5. _____

SECTION III DEMOGRAPHICS – MAIL, CURRENT METHOD ONLY

Now, Mrs. / Ms. / Mr. _____, I'd like to ask you some general questions about you and your family.

6. Are you the head of the household?
   ☐ 1) Yes -- ask questions in "YOU" format
   ☐ 2) No -- ask questions in "HEAD OF HOUSEHOLD" format and
   PROBE: Who is? _____ 6. _____

7. How old are you/head of household? _____ years 7. _____

8. What is your/head of household's marital status?
   ☐ 1) married ☐ 2) divorced ☐ 3) single ☐ 4) separated ☐ 5) widowed ☐ 6) other 8. _____

9. What was your/head of household's highest grade completed in school? _____ years 9. ___ ___

10. How many children are in the household? ___ ___ children 10. ___ ___

11. How old is the youngest child? ___ ___ years 11. ___ ___

12. How old is the oldest child? ___ ___ years 12. ___ ___

13. What language is spoken in your home? ☐ 1) English ☐ 2) Spanish ☐ 3) Other: _____ 13. _____

14. What would you say is your ethnic background?
   ☐ 1) Asian ☐ 2) Black ☐ 3) Filipino ☐ 4) Hispanic
   ☐ 5) Native American ☐ 6) White ☐ 7) Other _____ 14 _____

SECTION IV. A CHOICE FACTORS – HEALTH, ALL PERSONS

Next, Mrs. / Ms. / Mr. _____, I'd like to ask you about you and your family's health.

15. Do you have a family doctor right now?
   ☐ 1) Yes
   ☐ 2) No, then *PROBE: Where is you get most of your care right now?* _____ 15. _____

16. How satisfied are you with the care you are receiving from _____ ? Would you say you are:
   ☐ 1) Very Satisfied ☐ 2) Satisfied ☐ 3) So-So ☐ 4) Dissatisfied ☐ 5) Very Dissatisfied
   Comment: _____ 16. _____

17. How many times have you/head of household seen a doctor in the last year? _____ times 17 ___ ___

18. How many times have other members of the household seen a doctor in the last year? _____ times 18. ___ ___

19. How many times have you/head of household been hospitalized in the last year? _____ times 19. ___ ___

20. How many times have other members of your household been hospitalized in the last year? _____ times 20. ___ ___

21. Do you or any members of your household need medical care right now?
   ☐ 1) Yes ☐ 2) No *Probe/Comment:* _____ 21. _____

SECTION IV.B CHOICE FACTORS – DECISION, ALL PERSONS

The next set of questions is about your decision to:
☐ Join a PHP ☐ Stay with regular Medi-Cal

22. Had you ever heard of pre-paid health plans before you were contacted?
☐ 1) Yes ☐ 2) No *Probe/Comment:* _____ 22. _____

23. Have you or anyone in your household ever joined a PHP before?
☐ 1) Yes ☐ 2) No *Probe/Comment:* _____ 23. _____

24. What would you say is the main reason why you decided to:
A ☑ Join a PHP? 24. A _____
B *PROBE: Was it important to you that all of the services were under one roof?*
☐ 1) Yes ☐ 2) No _____ B _____
C *PROBE: What other reasons were important to you?* _____ C _____
D ✓ ☐ Stay with regular Medi-Cal? _____ D _____
E *PROBE: Was it important to you to choose your own doctor?*
☐ 1) Yes ☐ 2) No _____ E _____
F *PROBE: What other reasons were important to you?* _____ F _____

25. What would you say is the most important thing that
A ☑ PHPS should do for you? _____ 25. A _____
B ☐ Regular Medi-Cal should do for you? _____ B _____

SECTION V VERIFICATION – ENROLLEES ONLY

Now I'd like to check with you on some things that have or will be happening with your enrollment.

26. Has anyone from the health plan called or come to see you to ask if you have any questions about services?
A. Yes ☐ 1) Phone verification ☐ 2) Home verification ☐ 3) Other _____
B. No ☐ 4) 26. _____

27. Have you received a plan booklet explaining the services available?
☐ 1) Yes ☐ 2) No *Comment:* _____ 27. _____

28. Do you understand that joining the plan was completely voluntary and that you don't have to enroll to keep your food stamps or aid?
☐ 1) Yes ☐ 2) No *Comment:* _____ 28. _____

29A. Do you understand that during the first 30 days of membership you can disenroll (get out) for any reason?
☐ 1) Yes ☐ 2) No *Comment:* _____ 29. A _____

29B. Do you understand that after the first 30 days you can disenroll if you are dissatisfied after you use the plan's grievance system.
☐ 1) Yes ☐ 2) No *Comment:* _____ B _____

30. Did anyone check to see if you were under a doctor's care?
☐ 1) Yes ☐ 2) No *Comment:* _____ 30 _____

31. Do you understand that after your enrollment begins you can't to back to your current doctor unless he or she is on the list?
☐ 1) Yes ☐ 2) No *Comment:* _____ 31. _____

32. Your enrollment will probably be effective _____ you will know because you won't get your Medi-Cal card and the plan will send you an ID card instead. Until then, do you know how to get health care?
☐ 1) Yes ☐ 2) No *Advise:* _____ 32 _____

SECTION VI COMPREHENSION QUESTIONS -- ALL RESPONDENTS

Code 1 = Yes
2 = No

The last thing I'd like to do is see how well WE presented information about health care to you by asking you some questions about PHPs and regular Medi-Cal. Just answer TRUE if you think the question is true, or FALSE if you think the question is false: *Probe/Comment:* _____

33.	T	F	Pre-paid health plans are part of Medi-Cal.	33. ____
34.	T	F	Both regular Medi-Cal and pre-paid Medi-Cal provide basic health care at no cost to you.	34. ____
35.	T	F	People who are eligible for Medi-Cal may choose between regular Medi-Cal and pre-paid Medi-Cal.	35. ____
36.	T	F	Sometimes PHPs offer extra services that regular Medi-Cal doesn't.	36. ____
37.	T	F	People who use regular Medi-Cal have to use the same doctor all the time.	37. ____
38.	T	F	If you are using pre-paid Medi-Cal, you must go to that plan's facilities except in emergencies when you can't get there.	38. ____
39.	T	F	People on Medi-Cal who go to PHPs are guaranteed health care by the plan.	39. ____
40.	T	F	PHPs allow their members to go anywhere they want for health care.	40. ____
41.	T	F	People using regular Medi-Cal must find their own doctors.	41. ____
42.	T	F	It may take approximately 60 days to disenroll from a pre-paid health plan.	42. ____

Thank you very much Mrs. / Ms. / Mr. _____, for your time and cooperation.

You've been very helpful. Just one more thing before I go, I'd like to check and see if I have your correct address. Is it still

_____

_____

43. ☐ 1) Yes
☐ 2) No, get correct address. 43. ____

COMMENTS.

_____

_____

_____

_____

44. INTERVIEWER: _____ 44. |__|__|

45. DATE: _____ 45. |__|__|__|__|

46. TIME: _____ 46. |__|__|__|__|

47. Number of Tries: _____ 47. |__|__| |__|__|

48. Amount of Interview Time: _____ 48. |__|__| |__|__| Minutes

DEPARTMENT OF HEALTH SERVICES
[redacted] 455 Capitol Mall, Room 250
SACRAMENTO, CA 95814
(916) 322-4616

Appendix D: Data Collection Forms
Item 3b
Mail Choice Follow-Up Letter

Recently you were given information about Medi-Cal stickers and Medi-Cal health maintenance organizations at the Social Services Office. You were asked to choose between joining a prepaid health plan (PHP-HMO) and your regular Medi-Cal stickers. On the form you marked that you wanted to join

We have attempted to reach you by telephone, but have been unable to do so. We would like you to help us learn more about how the Medi-Cal Program is working by completing the enclosed questionnaire. Please fill it out and mail it back to us, within five days, in the self-addressed stamped envelope.

This will have no effect on your Medi-Cal benefits, but it will help us to improve the Medi-Cal Program.

Sincerely,

Suzanne Hutchins

Suzanne Hutchins
PHRED Project

Enclosures

State of California—Health and Welfare Agency

Appendix D: Data Collection Forms
Item 3b
Mail Choice Follow-Up Questionnaire

Department of Health Services

FOLLOW-UP QUESTIONNAIRE

NAME _____ NUMBER _____

Recently you were contacted at the Social Services office about joining a prepaid health plan. You were asked to choose between a PHP and your regular Medi-Cal card.

The form that you signed states that you want to join a prepaid health plan. Is this correct? ___ 1) Yes ___ 2) No

Next, we'd like to ask you about you and your family's health.

Do you have a family doctor right now?

___ 1) Yes

___ 2) No, then where do you get most of your care right now? _____

_____

How satisfied are you with the care you are now receiving? Would you say you are:

___ 1) Very Satisfied ___ 2) Satisfied ___ 3) So-So ___ 4) Dissatisfied ___ 5) Very Dissatisfied

Comment: _____

How many times have you/head of the household seen a doctor in the last year? _____ times

How many times have other members of the household seen a doctor in the last year? _____ times

How many times have you/head of the household been hospitalized in the last year? _____ times

How many times have other members of your household been hospitalized in the last year? _____ times

Do you or any members of your household need medical care right now?

___ 1) Yes ___ 2) No Comment: _____

The next set of questions is about your decision to join a prepaid health plan.

Had you ever heard of prepaid health plans before you were contacted?

___ 1) Yes ___ 2) No Comment: _____

Have you or anyone in your household ever joined a PHP before?

___ 1) Yes ___ 2) No Comment: _____

What would you say is the main reason why you decided to join a PHP: _____

_____

Was it important to you that all of the services were under one roof?

___ 1) Yes ___ 2) No Comment: _____

What other reasons were important to you? _____

What would you say is the most important thing that PHPs should do for you? _____

Now we'd like to check with you on some things that have or will be happening with your enrollment.

Has anyone from the health plan called or come to see you to ask if you have any questions about services?

A. Yes ___ 1) Phone ___ 2) Home visit ___ 3) Other _____
B. No ___ 4)

Have you received a plan booklet explaining the services available?

___ 1) Yes ___ 2) No Comment: _____

Do you understand that joining the plan was completely voluntary and that you don't have to enroll to keep your food stamps or aid?

___ 1) Yes ___ 2) No Comment: _____

Do you understand that after the first 30 days of membership you can disenroll (get out) for any reason?

___ 1) Yes ___ 2) No Comment: _____

Do you understand that after the first 30 days you can disenroll if you are dissatisfied after you use the plan's grievance system?

___ 1) Yes ___ 2) No Comment: _____

Did anyone check to see if you were under a doctor's care?

___ 1) Yes ___ 2) No Comment: _____

Do you understand that after your enrollment begins you can't go back to your current doctor unless he or she is on the list?

___ 1) Yes ___ 2) No Comment: _____

Do you know that you won't get your Medi-Cal card and the plan will send you an ID card instead. Until then, do you know how to get health care?

___ 1) Yes ___ 2) No Comment: _____

The last thing I'd like to do is see how well WE presented information about health care to you by asking you some questions about PHPs and regular Medi-Cal. Just circle TRUE if you think the question is true, or FALSE if you think the question is false:

Comment: _____

T F Prepaid health plans are part of Medi-Cal.

T F Both regular Medi-Cal and prepaid Medi-Cal provide basic health care at no cost to you.

T F People who are eligible for Medi-Cal may choose between regular Medi-Cal and prepaid Medi-Cal.

T F Sometimes PHPs offer extra services that regular Medi-Cal doesn't.

T F People who use regular Medi-Cal have to use the same doctor all the time.

T F If you are using prepaid Medi-Cal, you must go to that plan's facilities except in emergencies when you can't get there.

T F People on Medi-Cal who go to PHPs are guaranteed health care by the plan.

T F PHPs allow their members to go anywhere they want for health care.

T F People using regular Medi-Cal must find their own doctors.

T F It may take approximately 60 days to disenroll from a prepaid health plan

State of California—Health and Welfare Agency

Department of Health Services

MAIL INFORMATION FORM (MIF)

PHRED USE ONLY

1. Referra' Number: ☐☐ ☐☐☐☐☐☐☐☐

2. Date received by PHRED: ☐☐☐☐☐☐ (month, day, year)

3. Date mailed to plan: ☐☐☐☐☐☐ (month, day, year)

Name of Plan _____

22. Date MIF returned to PHRED: ☐☐☐☐☐☐

23. Follow-up needed? 1) ☐ Yes 2) ☐ No
If yes, describe: _____

24. Results of follow-up satisfactory?
1) ☐ Yes 2) ☐ No 3) ☐ Not Applicable
If no, describe: _____

PLAN USE BELOW THIS LINE

4. Referral's Name: (last, first, middle)
☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

5. Referral's Medi-Cal Number: ☐☐☐☐☐☐☐☐☐☐

6. Referral's Address: (house number, street or road)
☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ☐☐☐☐☐☐☐☐☐☐

7. (Zip) ☐☐☐☐☐

8. Referral's Phone Number: ☐☐☐ ☐☐☐ ☐☐☐☐

TO THE PLAN: If contact was not referred to you by PHRED, please fill in items 4–8 and indicate how referral was made:

9. 1) ☐ Self, result of mailer 2) ☐ Other: _____
The person named on this form has indicated an interest in:
10A. 1) ☐ Enrolling in 2) ☐ Learning about your plan.
Please contact this person within:
10B. ☐☐ days.
11. 1) ☐ By phone 2) ☐ At home

12. Return this form to PHRED by: ☐☐☐☐☐☐ (mo., day, year)

13. How many times was the individual contacted? ☐☐ (enter number)

DESCRIBE THE FIRST CONTACT:

14. Date: ☐☐☐☐☐☐ (month, day, year)

15. Method of contact: 1) ☐ Phone 2) ☐ Mail
3) ☐ Home 4) ☐

16. Results of first contact:
1) ☐ Verified enrollee 2) ☐ Enrolled other plan
3) ☐ No contact 4) ☐ Decision pending
5) ☐ Stay on regular Medi-Cal 6) ☐ Advance enrollment
7) ☐ Other: _____

IF MORE THAN ONE CONTACT, DESCRIBE THE LAST:

17. Date: ☐☐☐☐☐☐ (month, day, year)

18. Method of contact: 1) ☐ Phone 2) ☐ Mail
3) ☐ Home 4) ☐ Walk-in

19. Results of last contact:
1) ☐ Verified enrollee 2) ☐ Enrolled other plan
3) ☐ No contact 4) ☐ Decision pending
5) ☐ Stay on regular Medi-Cal 6) ☐ Advance enrollment
7) ☐ Other: _____

20 How many persons enrolled? ☐☐ (enter number)

21. Does this represent the referral's total family?
1) ☐ Yes 2) ☐ No (WHY NOT? _____)

MC 129 (7/78)

Appendix D: Data Collection Forms
Item 4
Mail Information Form

Office _____
Field Representative _____

Date Submitted _____

RIF - LISTING

Batch/Sequence Number	Name of Client	Medi-Cal Number	Plan	Date Sent	Date Due	Date Returned	Enrollment

State of California—Health and Welfare Agency

Department of Health Services

REFERRAL INFORMATION FORM (RIF)

Appendix D: Data Collection Forms
Item 6
Referral Information Form

1. Referral Number:

2. Referral's Name: (Last, First, Middle)

3. Referral's Medi-Cal Number:

4A. Referral's Address (House Number, Street or Road)

(City) (County)

4B. Zip

5. Referral's Phone Number:

6. Date Sent to Plan:

7. Date RIF returned to PHRED:

Name of Plan

To Plan: The above person has indicated that he/she wishes to enroll after receiving a presentation and/or information in the local Social Services Office.

8. Please contact this person within: (Days)

9. And return this form to PHRED by: Month Day Year

DESCRIBE THE FIRST CONTACT:

10. Date: (Month, Day, Year)

11. Method of Contact:
1) ☐ Phone 2) ☐ Mail
3) ☐ Home 4) ☐ Walk-in

12. Results of first contact:
1) ☐ Verified Enrollee 2) ☐ Enrolled Other Plan
3) ☐ No Contact 4) ☐ Decision Pending
5) ☐ Stay on Regular Medi-Cal 6) ☐ Other:

13. How many persons enrolled? (Enter number)

14. Does this represent the referral's total family?
1) ☐ Yes 2) ☐ No

16. Explain nonenrolling family members (if any)

15. How many not enrolled?

17. How many attempts were made before the individual was contacted? (Enter number)

IF MORE THAN ONE CONTACT, DESCRIBE THE LAST:

18. Date: (Month, Day, Year)

19. Method of Contact:
1) ☐ Phone 2) ☐ Mail
3) ☐ Home 4) ☐ Walk-in

20. Results of Last Contact:
1) ☐ Verified Enrollee 2) ☐ Enrolled Other Plan
3) ☐ No Contact 4) ☐ Decision Pending
5) ☐ Stay on Regular Medi-Cal 6) ☐ Other:

MC 731 (10/79)

Plan Enrollment Process
for
PHRED Participants

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I.

Current Method

When PHRED is studying the current enrollment method of the prepaid health plan, the following procedures apply:

1. There are no PHRED forms which the client needs to fill out in order to enroll. The plan will enroll the client using established procedures approved by the Department of Health Services.

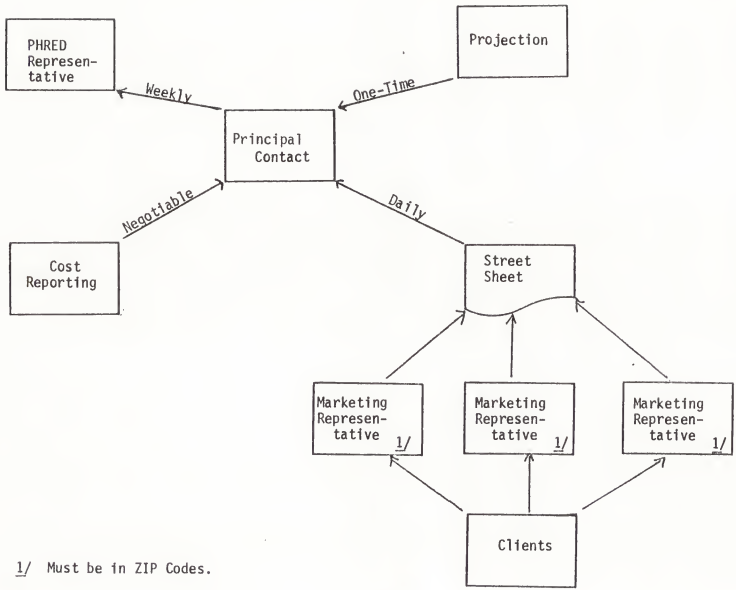
2. Plan representatives will complete the encounter forms, Presentation Results Report (Attachment A), for all encounters. A separate form will be used for each representative each day. These forms will be collected by the PHRED field representative on a weekly basis.

3. The encounters must take place in those ZIP codes comprising the demonstration site area (see Section IV). The plan must contact and attempt to make presentations to at least 200 eligible beneficiaries.

4. The plan is responsible for compiling and reporting the cost data required on the Marketing Costs Report (Attachment B). The PHRED field staff member will assist the responsible plan staff member in completing the form, if necessary.

5. Plan management will supply the PHRED Project with an estimation of the enrollment goal: the number of eligible beneficiaries they would expect to enroll in the demonstration area during the period. This estimate will be provided prior to the current method phase of the demonstrations.

CURRENT METHOD



1/ Must be in ZIP Codes.

PRESENTATION RESULTS REPORT

...me of Rep...tive: _____ Name of Plan: _____ Method: _____ Date: _____

(1) a. Street b. City	(2) Street Number	(3) Apt. Number	(4) Person Home? Yes/No	(5) a. Name of Person Contacted b. Medi-Cal Number	(6) Eligible for PHP? On Handout Yes/No (Y/N)	(7) Name of PHP If Enrolled	(8) Presentation Made Yes/No	(9) Refusal of Presentation Yes/No/N.A.	(10) Number of Enrollments	(11) Number of Persons in Family	(12) Time Started (Ex: 12:15 P.M.)	(13) Time Ended (Ex: 12:30 P.M.)	(14) Time in Transit (Ex: 010 Min.)	(15) a. Phone Number (If Available) b. Notes (Explain if 8th and any if other enrollment in ho...)
				a.										a.
				b.										b.
				a.										a.
				b.										b.
				a.										a.
				b.										b.
				a.										a.
				b.										b.
				a.										a.
				b.										b.
				a.										a.
				b.										b.

ATTACHMENT A (in printing)

7 80 (8 79)

-Instructional Guide-
PRESENTATION RESULTS REPORT

Under the heading, the following spaces need to be completed:

a) Name of representative

b) Name of plan

c) Method

c) Date

1(a) STREET - Street name on which person contacted lives.

1(b) CITY - Name of city in which person contacted lives.

2. STREET NUMBER - House number of person contacted.

3. APARTMENT NUMBER - Apartment number of person contacted, if applicable.

4. PERSON-AT-HOME - Yes, No, or Not Applicable (N/A). If yes, continue; if no or N/A skip to time block, note start and end times and, if applicable, any in-transit time. Under 17a, "Notes" should indicate the disposition of the contact.

5(a) NAME - Person contacted, coded; Last, First, Middle.

5(b) MEDI-CAL NUMBER - Medi-Cal number of person contacted if available; if not, leave blank

6. ELIGIBLE FOR PHP - Is person contacted eligible to enroll in a PHP? Code: Yes or No.

7. NAME OF PHP, IF ENROLLED - If the person contacted is currently enrolled in a PHP, indicate which. If not, write None.

8. PRESENTATION - Did the enroller make a presentation about the plan to the person contacted? Code: Yes or No; if no, reason should be given in 17a, "Notes."

9. REFUSE PRESENTATION - Did the person contacted refuse the presentation? Code: Yes or No; if no, indicate reason in 17a, "Notes."

10. NUMBER OF ENROLLMENTS - The number of enrollments that this contact directly yielded. Code: Number; Example: 2, 3 or 5.

11. NUMBER OF PERSONS IN FAMILY - The total number of persons in the family. Code: Number; Example: 2, 3 or 7.

12. TIME STARTED - The time at which work on this contact began. Code: XX:XX AM/PM. Example: 12:30 PM.

Mems 2

13. TIME ENDED - The time at which work on this contact ceased. Code: XX:XX AM/PM. Example: 12:45 PM.

14. TIME IN TRANSIT - Time spent going or coming from, or waiting for, a face-to-face contact. Code: XXX min. Example: 010 min.

15(a) PHONE NUMBER - The contacted person's telephone number. This item is of extreme importance. It must be obtained if at all possible.

15(b) NOTES - Notes on Disposition, or other notes such as reasons for "No Presentation" or "Refused Presentation." Plans which employ several marketing techniques will indicate which was used here.

ATTACHMENT B

Marketing Costs--Report for PHRED Demonstration

Plan _____

Method _____

Dates _____

I. Direct Costs

A. Direct Labor

1. All Enrollers $ _____
2. Clerical Staff $ _____
3. Verification Staff $ _____
4. Supervisory Staff $ _____
5. Marketing Manager $ _____

B. Payroll Additives (% of DL) $ _____

C. Mileage $ _____

D. Other Direct Costs (specify) $ _____

1. _____ $ _____
2. _____ $ _____
3. _____ $ _____

Total Direct Costs $ _____

II. Time Spent on PHRED

	Total Hours	PHRED Hours
A. All Enrollers	_____	_____
B. Clerical Staff	_____	_____
C. Verification Staff	_____	_____
D. Supervisory Staff	_____	_____
E. Marketing Manager	_____	_____

III. Indirect Costs (total monthly)

A. Materials (Printed)	$ _____
B. Advertising Costs	$ _____
C. Equipment and Other Supplies	$ _____
D. Telephone	$ _____
E. Utilities	$ _____
F. Rent	$ _____
G. Depreciation	$ _____
H. Other (Specify)	$ _____
1. _____	
2. _____	
3. _____	
Total Indirect Costs	$ _____

Instructions for Marketing Costs Report

I. Purpose of Report

The purpose of the Marketing Costs Report for the PHRED demonstrations is to determine accurately that portion of costs borne by the prepaid health plan during each method demonstrated by the PHRED Project. Some methods require little effort (and, therefore, little cost) on the part of the plan while others require more effort and more expense. The information will be integrated with state/county cost information and encounter data in the evaluation of each method.

II. When a Report is Required

At the end of each demonstrated method, the report must be completed by each plan for each welfare office site with which the plan is involved with. Therefore, it would be wise to keep aggregate data during the method being demonstrated (such as, hours devoted to PHRED) to make the report completion easier.

III. Direct Costs - Completing the Form

A. The direct costs reported should reflect the total costs expended by that portion of the marketing/verification staff devoted to the Medi-Cal program during the period under consideration.

B. Example: If a plan has one full-time marketing manager, one verifier, two enrollers, and three clerical staff assigned to the marketing/ verification of Medi-Cal clients and the method being demonstrated is a 10-week period, the plan should determine the monthly costs for each category of personnel and multiply that by 2.5 (10 weeks) to complete the form.

C. Personnel who work only part-time should be included with appropriate adjustments to show accurate payment for work accomplished.

IV. Time Spent - Completing the Form

A. The key to accurately completing the Marketing Cost Report is to keep close watch on the hours expended by plan staff for the PHRED Project. All cost information that is reported (Parts I and III) would normally be accumulated for the plan's annual and quarterly fiscal reporting, but the hours spent performing PHRED-related activities require a little extra effort. The hours reported will then be used to determine percentages of time expended on PHRED activities and then converted to percentages of costs.

B. The total hours for each category listed should be equal to the amount of time that marketing/verification staff was paid for as reported in Part IA. (Therefore, if the plan had a loss of 25 hours due to sick leave during the 10-week period for which it was reporting but the plan pays for that sick leave, the 25 hours would be included in the total hours, since the pay factor was included in Part IA.)

C. The PHRED hours for each category listed should equal the actual hours spent by plan personnel in performing PHRED-related activities.

V. Indirect Costs - Completing the Form

A. Recognizing that some indirect costs fluctuate during the course of the year (such as the cost of reprinting material stock), it appears that the fairest method for distributing these costs across the time frame for the PHRED Project demonstrations is to take a percentage for PHRED of the average monthly indirect costs accrued over a one-year period. Consequently, you are to fill in this portion of the form with a monthly average for the Medi-Cal administrative cost component based on the previous one-year experience.

B. Example 1

Plan X is currently paying $400 a month for administrative offices as overhead for their Medi-Cal clients. The plan has paid this amount for the past six months; prior to that, the rent for the Medi-Cal portion was $350 a month. Looking back over the past 12 months, we determine that the rent had remained at $350 for six months then rose to $400 for the next six months. The average rent for this 12-month period for the Medi-Cal portion therefore, is $375. This amount should be entered on the form.

C. Example 2

Plan X has decided to do a one-time mailing to a target area to announce the opening of a new clinic. The mailing is directed to resident addresses only although the plan knows that there is a 45 percent concentration of Medi-Cal clients in the target area. The plan first needs to determine the total cost of the mailing (printing, postage, art work, return referrals, etc). Since in this instance it would be difficult to segregate out the Medi-Cal-only costs, take 45 percent of the total, divide that by 12 to spread out over a one-year period and enter the amount under III(B), Advertising Costs.

II.

Mailing Method

1. During the mailing method, the PHRED Project will directly mail to all eligible Medi-Cal beneficiaries residing in the ZIP codes served by the demonstration site welfare office (see Section IV) the following:

   A. A letter of explanation
   B. The PHRED Project brochure
   C. Plan folders compiled by the PHRED Project
   D. A choice card (Attachment C)

2. The choice card (Attachment C) will be returned by the beneficiary directly to the PHRED Project. If the beneficiary indicates an interest in the plan, the PHRED Project will attach the choice card to a Mailing Information Form (MIF) (Attachment D) and will send both the form and the choice card to the selected plan.

3. For those self enrolling on the card, the plan will attempt to contact the beneficiary by phone, giving the combined orientation verification (Attachment E). Referrals not responding to telephone calls or without telephones should be sent form letters (Attachment F) to encourage them to telephone the plan. The plan will tape record presentations. The plan will then enter the results on the MIF and return the MIF to the PHRED Project within the time specified on the MIF. Only if the beneficiary is not available by phone will the plan contact the beneficiary through a home visit. If the beneficiary's enrollment is verified, the plan will complete a standard enrollment document as required by the Department of Health Services Prepaid Health Plan Branch and attach the choice card (Attachment C) to the enrollment document. It is not necessary for the plan to secure the beneficiary's signature on the standard enrollment document if it is already on the choice card.

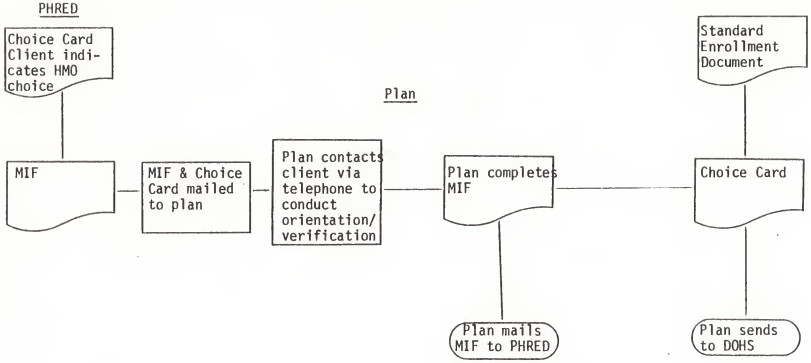
4. If the beneficiary has not enrolled on the card, but has merely requested information, the plan may send information in the mail or may make a home or telephone call as indicated on the choice card. NOTE: These referrals do require signed enrollment forms.

5. Beneficiaries on Medicare assistance status should be sent the Medicare release form letter (Attachment G).

6. The PHRED field staff member will devise a method with plan central staff to estimate the cost of acting on the referrals from the PHRED Project using the Marketing Costs Report (Attachment B).

MAILING INFORMATION FORM PROCESSING

PLAN PARTICIPATION



1. PHRED Project initiates MIF and sends it with Choice Card to Plan.

1. The Plan may send letter or representative to the client only if unable to contact by telephone.
2. Orientation/verification must be taped

1. Mail to:

   PHRED Project
   Membership Studies
   455 Capitol Mall
   Suite 250
   Sacramento, CA
   95814

1. Plan transfers information from Choice Card to standard enrollment document, staples Choice Card to back of document and sends to:

   Supervising Clerk
   PHP Branch
   714 P Street, Room 1540
   Sacramento, CA 95814

Please take a few minutes to answer these questions:

1. Do you have a regular source of health care?
   1) ☐ Yes 2) ☐ No
2. If you or a member of your household is sick, where do you usually go for care?
   1) ☐ Private doctor 2) ☐ County clinic
   3) ☐ County hospital 4) ☐ Emergency room
   5) ☐ Other
3. Do you or a member of your household need medical care now? 1) ☐ Yes 2) ☐ No
4. Had you ever heard of Health Maintenance Organizations (HMOs) before you received this?
   1) ☐ Yes 2) ☐ No
5. Have you or a member of your family ever joined an HMO? 1) ☐ Yes 2) ☐ No

Mail back to State Dept. of Health Services — No stamp necessary.

(Vease el otro lado para la version en espanol)

- Please tell us what you have decided about your health care by marking:
  - Box A — Enroll me and my family in an HMO.
  - Box B — I'd like to learn more about HMOs, but keep my sticker card for now.
  - Box C — I'd like to keep my monthly sticker card.

- If you have chosen an HMO, check the box by the plan's name below and tell us how you want to be contacted.

☐ Home Visit ☐ Telephone Call

☐ Rockridge

Here is the choice: (Please give information below for each family member, including yourself.)

Name Last, First, Middle	Relationship to You?	Sex	Birthday Mo /Day/Yr.	A Enroll In An HMO	B Learn More About HMOs	C Monthly Sticker Card
	(self)					

Print Name	Sign	Date	Phone

State of Cali[illegible]ealth and Welfare Agency

Att[illegible]nt D

Department of Health Services

MAIL INFORMATION FORM (MIF)

PHRED USE ONLY

1. Referral Number: ☐ ☐☐☐☐☐☐☐

2. Date received by PHRED: ☐☐☐☐☐☐
(month, day, year)

3. Date mailed to plan: ☐☐☐☐☐☐
(month, day, year)

Name of Plan _____

22. Date MIF returned to PHRED: ☐☐☐☐☐☐

23. Follow-up needed? 1) ☐ Yes 2) ☐ No
If yes, describe: _____

24. Results of follow-up satisfactory?
1) ☐ Yes 2) ☐ No 3) ☐ Not Applicable
If no, describe: _____

PLAN USE BELOW THIS LINE

4. Referral's Name: (last, first, middle)
☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

5. Referral's Medi-Cal Number: ☐☐☐☐☐☐☐☐☐☐

6. Referral's Address: (house number, street or road)
☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ☐☐☐☐☐☐☐☐☐☐

7. (Zip) ☐☐☐☐☐

8. Referral's Phone Number: ☐☐☐ ☐☐☐ ☐☐☐☐

TO THE PLAN: If contact was not referred to you by PHRED, please fill in Items 4–8 and indicate how referral was made:

9. 1) ☐ Self, result of mailer 2) ☐ Other: _____

The person named on this form has indicated an interest in:

10A. 1) ☐ Enrolling in 2) ☐ Learning about your plan.

Please contact this person within:

10B. _____ days.

11. 1) ☐ By phone 2) ☐ At home

12. Return this form to PHRED by: ☐☐☐☐☐☐ (mo., day, year)

13. How many times was the individual contacted? ☐☐ (enter number)

DESCRIBE THE FIRST CONTACT:

14. Date: ☐☐☐☐☐☐ (month, day, year)

15. Method of contact: 1) ☐ Phone 2) ☐ Mail
3) ☐ Home 4) ☐

16. Results of first contact:
1) ☐ Verified enrollee 2) ☐ Enrolled other plan
3) ☐ No contact 4) ☐ Decision pending
5) ☐ Stay on regular Medi-Cal 6) ☐ Advance enrollment
7) ☐ Other: _____

IF MORE THAN ONE CONTACT, DESCRIBE THE LAST:

17. Date: ☐☐☐☐☐☐ (month, day, year)

18. Method of contact: 1) ☐ Phone 2) ☐ Mail
3) ☐ Home 4) ☐ Walk-in

19. Results of last contact:
1) ☐ Verified enrollee 2) ☐ Enrolled other plan
3) ☐ No contact 4) ☐ Decision pending
5) ☐ Stay on regular Medi-Cal 6) ☐ Advance enrollment
7) ☐ Other: _____

20 How many persons enrolled? ☐☐ (enter number)

21. Does this represent the referral's total family?
1) ☐ Yes 2) ☐ No (WHY NOT? _____)

AC [illegible] (7/73)

-Instructional Guide-
MAIL INFORMATION FORM

This document will be completed by PHRED/PLAN staff for every person from the mailing demonstration who wishes more information about and/or enrollment in a PHP.

The following account is an item-by-item description of the data needed for each question on the MIF. Responsibilities for each item are indicated within parentheses.

1. REFERRAL NUMBER - (PHRED) PHRED staff will indicate the log number given to each individual from the listing of preprinted labels. The first two digits will be the code number for the particular plan being contacted.

2. DATE RECEIVED BY PHRED - (PHRED) PHRED staff will indicate the date the mailer card was delivered to the PHRED Project in the following order - month, day, year. Example - March 20, 1979 would be |0|3|2|0|7|9|.

3. DATE MAILED TO PLAN - (PHRED) PHRED staff will indicate the date the mailer card was sent to the plan in the following order - month, day, year. Example - March 23, 1979 would be |0|3|2|3|7|9|.

4. REFERRAL NAME - (PHRED/PLAN) PHRED staff will indicate the respondent's name if referring the individual to the plan; the plan will indicate the respondent's name if individual is self-referred. The name should be printed in the following order - last, first, middle with a space skipped between last and first and between first and middle.

5. REFERRAL'S MEDI-CAL NUMBER - (PHRED/PLAN) PHRED staff will indicate the respondent's Medi-Cal number if referring the individual to the Plan; plan will indicate the respondent's Medi-Cal number if individual is self-referred.

6-7. REFERRAL'S ADDRESS - (PHRED/PLAN) PHRED staff will indicate the respondent's address if referring individual to the plan; plan will indicate the respondent's address if individual is self-referred. The address should be filled in as follows:

   A. The respondent's house number followed by street or road with one space skipped between number and street. If respondent resides in an apartment, apartment number should be entered after street with one space skipped in between.

   B. Enter the name of the city in which the respondent lives.

   C. Enter the name of the county in which the respondent lives.

   D. Enter the respondent's ZIP code.

8. REFERRAL'S PHONE NUMBER - (PHRED/PLAN) PHRED staff will indicate the respondent's phone number if referring the individual to the plan. plan will indicate the respondent's phone number if individual is self-referred. Phone number should be entered in the following order - area code (3 digits), prefix (3 digits), number (4 digits).

9. OTHER REFERRAL - (PLAN) The plan will indicate how the respondent was referred, if not done by PHRED. 1=self referred as a result of the mailer, 2=other (please specify).

10A. TYPE OF INTEREST - (PHRED) PHRED staff will indicate the type of interest the respondent has identified - 1=enrollment or 2=learning about.

10B. NUMBER OF DAYS TO CONTACT - (PHRED) PHRED staff will indicate the desired number of days the plan has to contact the respondent.

11. METHOD OF CONTACT DESIRED - (PHRED) PHRED staff will indicate the method by which the respondent wishes to be contacted by the plan - 1=phone call, 2=home visit, or 3=mail.

12. RETURN FORM TO PHRED BY - (PHRED) PHRED staff will indicate the date the MIF should be returned by the plan in the following order: month, day, year.

13. NUMBER OF TIMES CONTACTED - (PLAN) The plan should indicate the total times the individual was contacted. Example - 4 visits would be |0|4|. (See General Specifications for definition of a contact.)

14. DATE OF FIRST CONTACT - (PLAN) The plan should indicate the date of their first contact with the individual in the following order - month, day, year. Example - April 5, 1979 would be |0|4|0|5|7|9|.

15. METHOD OF FIRST CONTACT - (PLAN) The plan should indicate the method of their first contact with the individual with - 1=phone call, 2=mailed material, 3=home visit, 4=walk-in (respondent walks into plan on own).

16. RESULTS OF FIRST CONTACT - (PHRED/PLAN) The plan should indicate the results of their first contact with the individual with - 1=verified enrollee, 2=enrolled in another Plan, 3=no contact made, 4=decision pending, 5=stay on regular Medi-Cal, 6=advance enrollment.

    Advanced enrollment will be marked on the MIF by PHRED before referred to the plan to indicate that the beneficiary has enrolled by mail pending only verifications and orientation.

NOTE: IF THERE WAS MORE THAN ONE CONTACT, THE PLAN SHOULD FILL IN ITEMS 17-19. IF NOT, THESE ITEMS SHOULD BE LEFT BLANK. BE SURE NOT TO MARK THE RESPONDENT AS ENROLLING ON BOTH CONTACTS.

17. DATE OF LAST CONTACT - (PLAN) The plan should indicate the date of their last contact with the individual in the following order - month, day, year. Example - April 10, 1979 would be 0|4|1|0|7|9|.

18. METHOD OF LAST CONTACT - (PLAN) The plan should indicate the method used on their last contact with the individual with - 1=phone call, 2=mailed material, 3=home visit, 4=walk-in (respondent walks into Plan, self-referred).

19. RESULTS OF LAST CONTACT - (PLAN/PHRED) The plan should indicate the results of their last contact with the individual with - 1=verified enrollee, 2=enrolled in another Plan, 3=no contact made, 4=decision pending, 5=stay on regular Medi-Cal, 6=advance enrollment.

    Advanced enrollment will be marked on the NIF by PHRED before referred to the plan to indicate that the beneficiary has enrolled by mail pending only verifications and orientation.

NOTE: BE SURE NOT TO MARK THE RESPONDENT AS ENROLLING ON BOTH CONTACTS.

20. NUMBER OF PERSONS ENROLLED - (PLAN) The plan should indicate the number of persons enrolled as a direct result of this referral. IF NO PERSONS ENROLL, MARK |0|0|. In other cases, indicate the exact number, Example - 6 persons would be |0|6|.

21. REPRESENT ENTIRE FAMILY - (PLAN) The plan should indicate whether or not the number of persons enrolled represents the respondent's entire family. IF NO ONE ENROLLED, MARK NOT APPLICABLE. 1=Yes, 2=No, 3=Not Applicable.

22. DATE MIF RETURNED TO PHRED - (PHRED) PHRED staff should indicate the date the MIF was received by them in the following order - month, day, year.

23. FOLLOW-UP NEEDED - (PHRED) PHRED staff should indicate whether or not a follow-up is needed on the individual to ensure proper coding of data or completeness of data. Code: 1=Yes, 2=No. If yes, describe the problem and indicate who should be contacted.

24. FOLLOW-UP SATISFACTORY - (PHRED) PHRED staff should indicate whether or not the results of the follow-up were satisfactory (problem solved). Code: 1=Yes, 2=No, and 3=Not Applicable. If no, describe why not.

ATTACHMENT E-1

PLAN VERIFICATION QUESTIONNAIRE
(PHRED Project Membership Studies)

(for verification by phone)

Statement to applicant: Hello, Mr./Mrs./Ms. _____, this is _____ of _____ Health Plan. I am here to let you know that we are very happy that you have applied for enrollment in our plan and to be sure that you have an opportunity to find out anything else you would like to know about belonging to the health plan. If you don't mind, so that we can both be sure you know everything you should know before you actually use the plan, I'll ask you a few questions first and then you can ask me if there is anything else. Is this all right with you? (I am tape recording this interview so that the State Department of Health Services can verify that you do want to enroll. Is this all right with you?_____).

First, I need to be sure that we have all the facts straight. Your current address and telephone number are _____ and _____. Your Medi-Cal number is _____. (If applicable:) You also enrolled some members of your family: The names and Medi-Cal numbers I have are: _____, _____; _____, _____; _____, _____; etc.... Now I need to check a few details about your application and your eligibility. Did you get a regular Medi-Cal card this month? _____ According to our records you choose the plan by mail or at the _____ Social Services office on _____. Is this correct? _____

We need to be sure that no one in your home has applied for enrollment or been enrolled in this or any other Prepaid Health Plan this year so that we won't have you enrolled in two plans at once. (pause for response)

Now, I'd like to go over some important information about your enrollment. If there is something you don't understand, please stop me, and we'll talk about it. First, do you understand that you have applied for enrollment in _____ _____ health plan? and that your enrollment must be reviewed by the State Department of Health Services? _____ If you become/continue to be eligible for Medi-Cal, it will be effective and you will be a member of our plan within about _____ days. (pause) You will know when you are offically enrolled because you will receive a special identification card instead of your regular monthly Medi-Cal card. Do you have any questions about not getting your regular card any more when you are a plan member?

It is really important for you to carry your new identification card with you at all times in case you need emergency services, because you should present this card whenever you have an appointment or need any care or treatment. I hope that you clearly understand that when you are a member of our plan you will no longer be able to visit your current doctor or dentist (unless they work for our plan). Does this cause any problems for you? _____ Are you

now receiving medical or dental care that you feel could only be continued by your current doctor or dentist and could not be transferred to one of our providers? _____ You should remember if you receive care from a doctor, dentist, or hospital that is not with our health plan, except in an emergency, you will have to pay for these bills yourself. When you become a member, Medi-Cal will pay us to provide all the care you need and you must use our services because they are already paid for you.

Incidentally, do you have a way to get health care until you receive your _____ (PHP) card? ____ If you don't have a doctor, or need some other care, you are welcome to come to our (health center, clinic, offices, etc.) with your Medi-Cal card. You should bring the reminder slip you got at the Social Services office/the letter you got from the State Department of Health Services after you enrolled by mail/so our receptionist will know you are going to be a member.

It would be a good idea for you to come to our health center (clinic, offices, etc.) anyway to see what we are like during the next month or so because the first 30 days after your enrollment is effective is a period during which you can disenroll for any reason. After that, do you know what to do if you have a problem with the health plan and think you might want to disenroll? _____ (confirm) You may request disenrollment or make a complaint to our Grievance Coordinator. If we can't please you, your disenrollment request will be sent to the State Department of Health Services. The whole process usually takes about 45 days but could take longer for the State's computer to handle.

I hope you understand that joining our plan is voluntary and completely your choice. It does not affect your monthly check, food stamps, or your right to medical benefits. (pause for response) _____

Do you have any questions about your enrollment application and the things we have just discussed? _____ You will be getting more information about our services in the mail as soon as your membership is processed.

Let's see. You will be getting care at our _____ health center, clinic, office, etc.). The regular office hours there are _____. Is that convenient for you? ____ Will you have any trouble getting there on your own? ____ You do understand that we do/do not provide transportation for routine or non-emergency care? (pause) _____

(Note to plan: Add other plan-specific use information--e.g., appointment-making, child care, CHDP, etc.)

_____

_____

_____

_____

_____

_____

_____

_____

You should understand what to do in an emergency. (Explain, ask for understanding) _____

_____

_____

That's everything I wanted to check over with you. Do you have any questions? (Note) _____

_____

_____

Verifier _____

Date _____

ATTACHMENT E-2

PLAN VERIFICATION QUESTIONNAIRE
(PHRED Project Membership Studies)

(for in-home or in-office verification)

Statement to applicant: Hello, Mr./Mrs./Ms. _____, this is _____ of _____ Health Plan. I am here to let you know that we are very happy that you have applied for enrollment in our plan and to be sure that you have an opportunity to find out anything else you would like to know about belonging to the health plan. If you don't mind, so that we can both be sure you know everything you should know before you actually use the plan, I'll ask you a few questions first and then you can ask me if there is anything else. Is this all right with you? (I am tape recording this interview so that the State Department of Health Services can verify that you do want to enroll. Is this all right with you?_____).

First, I need to be sure that we have all the facts straight. Your current address and telephone number are _____ and _____. Your Medi-Cal number is _____. (If applicable:) You also enrolled some members of your family: The names and Medi-Cal numbers I have are: _____, _____; _____, _____; _____, _____; etc.... Now I need to check a few details about your application and your eligibility. Did you get a regular Medi-Cal card this month? _____ According to our records you choose the plan by mail/or at the _____ Social Services office on _____. Is this correct? _____

We need to be sure that no one in your home has applied for enrollment or been enrolled in this or any other Prepaid Health Plan this year so that we won't have you enrolled in two plans at once. (pause for response)

Now, I'd like to go over some important information about your enrollment. If there is something you don't understand, please stop me, and we'll talk about it. First, do you understand that you have applied for enrollment in _____ _____ health plan? and that your enrollment must be reviewed by the State Department of Health Services? _____ If you become/continue to be eligible for Medi-Cal, it will be effective and you will be a member of our plan within about _____ days. (pause) You will know when you are offically enrolled because you will receive a special identification card instead of your regular monthly Medi-Cal card. Do you have any questions about not getting your regular card any more when you are a plan member?

It is really important for you to carry your new identification card with you at all times in case you need emergency services, because you should present this card whenever you have an appointment or need any care or treatment. I hope that you clearly understand that when you are a member of our plan you will no longer be able to visit your current doctor or dentist (unless they work for our plan). Does this cause any problems for you? _____ Are you

now receiving medical or dental care that you feel could only be continued by your current doctor or dentist and could not be transferred to one of our providers? _____ You should remember if you receive care from a doctor, dentist, or hospital that is not with our health plan, except in an emergency, you will have to pay for these bills yourself. When you become a member, Medi-Cal will pay us to provide all the care you need and you must use our services because they are already paid for you.

Incidentally, do you have a way to get health care until you receive your _____ _____(PHP) card? ____ If you don't have a doctor, or need some other care, you are welcome to come to our (health center, clinic, offices, etc.) with your Medi-Cal card. You should bring the reminder slip you got at the Social Services office/the letter you got from the State Department of Health Services after you enrolled by mail/so our receptionist will know you are going to be a member.

It would be a good idea for you to come to our health center (clinic, offices, etc.) anyway to see what we are like during the next month or so because the first 30 days after your enrollment is effective is a period during which you can disenroll for any reason. After that, do you know what to do if you have a problem with the health plan and think you might want to disenroll? ____ (confirm) You may request disenrollment or make a complaint to our Grievance Coordinator. If we can't please you, your disenrollment request will be sent to the State Department of Health Services. The whole process usually takes about 45 days but could take longer for the State's computer to handle.

I hope you understand that joining our plan is voluntary and completely your choice. It does not affect your monthly check, food stamps, or your right to medical benefits. (pause for response) _____

Do you have any questions about your enrollment application and the things we have just discussed? _____ You will be getting more information about our services in the mail as soon as your membership is processed.

Let's see. You will be getting care at our _____ health center, clinic, office, etc.). The regular office hours there are _____. Is that convenient for you? ____ Will you have any trouble getting there on your own? ____ You do understand that we do/do not provide transportation for routine or non-emergency care? (pause) _____

(Note to plan: Add other plan-specific use information--e.g., appointment-making, child care, CHDP, etc.)

_____

_____

_____

_____

_____

_____

_____

_____

You should understand what to do in an emergency. (Explain, ask for understanding) _____

That's everything I wanted to check over with you. Do you have any questions? (Note) _____

Verifier _____

Date _____

ATTACHMENT F

Form letter to those without phones or not answering phone

Dear:

On (date), in the (social services office name), you decided to enroll in (plan name). We're very glad you did and look forward to serving you and your family. Before we can, however, there is another step in the enrollment process which we have to complete with you. We need to talk with you over the phone and give you some more information about how our plan works and be sure that you understand what it means to be a member of (plan name).

Because we don't have a telephone number for you (or because we have not been able to reach you by phone), we need to ask you to call us, so that we can continue processing your enrollment. As soon as possible, please call me (or name of verifier-orienter), at (plan number). If you prefer, you may come into our office at (_____) and ask for me (me or whomever) and we'll go through the information together.

We look forward to hearing from you soon so that you can become a member of (plan name). If you already have a Medi-Cal card, remember that you can use it at our plan until your enrollment is in effect and you have one of our membership cards. Please bring this letter with you if you do come in with your card so that our staff will know you have decided to enroll.

Sincerely,

Plan Representative

ATTACHMENT G

Form letter to SSI-SSP recipients who enroll by mail

Dear :

Recently you responded to information sent to you about Medi-Cal by the State Department of Health Services. You decided that you wanted to receive your Medi-Cal benefits by enrolling in our health plan. (plan name) is very pleased that you have decided to become a member and Mr/Mrs _____ was happy to verify your enrollment after talking with you on the telephone about the plan recently (or date).

To complete the enrollment process, we need just one more piece of paper, assignment of your Medicare benefits to the plan, since you will be getting all of your health care through our providers and facilities. Please sign the enclosed assignment and release of information form for us and return it to us in the enclosed stamped envelope. We will let Medicare know that you have become a member of our plan.

We are looking forward to welcoming you as a member. As soon as we get the form back from you we will send the information to Medicare and to Medi-Cal and you will then receive a membership card from (plan name) as soon as everything is effective. In the meantime, if you need services, you may bring your monthly sticker Medi-Cal card to our (health center, facility, clinic, offices, whatever) and we will take care of you there. Please bring this letter with you when you come in so that our staff may recognize you as a soon to be member. If you have any questions, please call me (or whomever) at (phone number).

Sincerely,

Plan Representative

ATTACHMENT B

Marketing Costs--Report for PHRED Demonstration

Plan _____

Method _____

Dates _____

I. Direct Costs

A. Direct Labor

1. All Enrollers $ _____
2. Clerical Staff $ _____
3. Verification Staff $ _____
4. Supervisory Staff $ _____
5. Marketing Manager $ _____

B. Payroll Additives (% of DL) $ _____

C. Mileage $ _____

D. Other Direct Costs (specify) $ _____

1. _____ $ _____
2. _____ $ _____
3. _____ $ _____

Total Direct Costs $ _____

II. Time Spent on PHRED

	Total Hours	PHRED Hours
A. All Enrollers	_____	_____
B. Clerical Staff	_____	_____
C. Verification Staff	_____	_____
D. Supervisory Staff	_____	_____
E. Marketing Manager	_____	_____

III. Indirect Costs (total monthly)

A. Materials (Printed) $ _____

B. Advertising Costs $ _____

C. Equipment and Other Supplies $ _____

D. Telephone $ _____

E. Utilities $ _____

F. Rent $ _____

G. Depreciation $ _____

H. Other (Specify) $ _____

1. _____

2. _____

3. _____

Total Indirect Costs $ _____

III.

All Welfare Office Methods

For each of the methods being demonstrated in the welfare office (Pamphlet Only Method, Eligibility Worker Presentation, PHRED Representative Presentation, Audio-Visual Presentation, and PHP Representative Presentation), the plan will act on referrals.

Each family that receives a PHRED information presentation will complete a Choice and Presentation Information Form (CAPIF) (Attachment H). Those who elect to enroll in a plan will be referred to the plan as follows:

1. The CAPIF forms will be collected by the PHRED field staff in welfare offices.

2. The top portion of the CAPIF and a Referral Information Form (RIF) (Attachment I) will be mailed to the appropriate plans for follow-up. The copy will be delivered by the PHRED staff member to our Project office in Sacramento. The copy will be delivered by the PHRED staff member to Project officers in Sacramento.

3. The plan, upon receipt of a CAPIF, will first attempt to contact the individual by telephone, give the combined orientation-verification (Attachment E-1) (which will be taped by the plan) and complete the Referral Information Form (RIF). If the beneficiary is not available by telephone, the plan should send the form letter requesting the beneficiary to call the plan to complete the enrollment (Attachment F). (Letters returned because of incorrect address, "moved", etc., should be returned to PHRED field rep. for correction through welfare office files.) Only if the beneficiary so requests may the plan do a home visit. The verification script (Attachment E-2) must be used during a home visit.

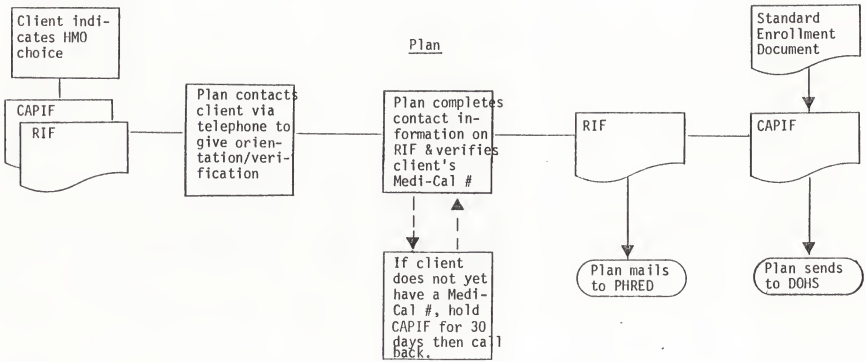
4. The RIF will be returned to the PHRED Project by the date designated in Item 9 on the form. The Plan will submit the taped orientation-verification to PHRED with the RIF.

5. The plan will complete a standard enrollment document, attach the CAPIF to it, and process the enrollment document as usual. It is not necessary for the plan to secure a signature on the enrollment form. The signature on the CAPIF is sufficient. Note: because the intake cases may not be eligible by the time of the first cut-off (if the county is slow in reporting after giving a Medi-Cal number to the enrolling beneficiary), plans should keep a copy of the signed CAPIF and the enrollment application and resubmit the two the next month if the enrollee does not appear on the '1s' list. New intake enrollment cases are not put in pended status if they do not match the first month. They should be resubmitted for at least two following months if they do not appear in the capitation listing. The Department will have the original CAPIF on file, it is merely necessary to supply copies of the CAPIF and the application, as if for the first time, for the subsequent months.

6. The PHRED field staff member will devise a method with plan central staff to estimate the cost of acting on referrals from the PHRED Project using the Marketing Costs Report (Attachment B).

REFERRAL INFORMATION FORM PROCESSING

PLAN PARTICIPATION


Welfare Office
Client indicates HMO choice
CAPIF
RIF
Plan contacts client via telephone to give orientation/verification
Plan
Plan completes contact information on RIF & verifies client's Medi-Cal #
If client does not yet have a Medi-Cal #, hold CAPIF for 30 days then call back.
RIF
Plan mails to PHRED
Standard Enrollment Document
CAPIF
Plan sends to DOHS

1. PHRED Representative routes original CAPIF and RIF to Plan

1. The plan may send a representative or a letter to the client only if unable to contact by telephone.
2. Orientation/verification must be taped.

1. Mail to:

   PHRED Project
   Membership Studies
   455 Capitol Mall
   Suite 250
   Sacramento, CA
   95814

1. Plan fills out Standard Enrollment Document and staples CAPIF to back.
2. Mail to:

   Supervising Clerk
   PHP Branch
   714 P Street,
   Room 1540
   Sacramento, CA
   95814

ATTACHMENT H

ate of California—Health and Welfare Agency

Department of Health Services

CHOICE AND PRESENTATION INFORMATION FORM FOR MEDI-CAL BENEFITS

See Reverse For Privacy Information Practice Act Notification

STRUCTIONS: *Please fill in the following information about your health care decision. REMEMBER, a choice should be made for each ember of the family for whom you are applying. If you choose to enroll in a Medi-Cal Health Maintenance Organization (HMO/PHP), check e box labeled HMO.*
you choose a Medi-Cal monthly sticker card, check the box labeled CARD.

C

O THE STATE DEPARTMENT OF HEALTH SERVICES: I have made a choice between receiving a Medi-Cal monthly sticker card and rolling in a Medi-Cal Health Maintenance Organization (HMO/PHP). If I (we) are eligible for Medi-Cal, I wish to receive health care benefits r myself and the family members for whom I am authorized to sign as I have indicated in the box below:

1. NAME (Please Print) Last First Middle	2. Relation To You:	3. Decision Check One HMO	CARD	4. MEDI-CAL NUMBER	5. BIRTHDATE Mo. Day Year	6. SEX F=Female M=Male
a.	Self					
b.						
c.						
d.						
e.						
f.						
g.						

F YOU HAVE CHOSEN AN HMO/PHP, CHECK THE BOX BY THE PLAN'S NAME AND TELL US OW YOU WANT TO BE CONTACTED:

- ☐ California Medical Group
- ☐ CompreCare
- ☐ Kaiser
- ☐ Watts Health Plan

8. Contact me: 1) ☐ At home 2) ☐ By phone

9. Do you have any other Health Insurance? 1) ☐ Yes 2) ☐ No
Company: _____

PLEASE ANSWER THESE QUESTIONS ABOUT YOUR DECISION:

10. Was your decision the same for all members of your family? 1) ☐ Yes 2) ☐ No

If you marked no, why was it different for some members?

_____

ATTACHMENT H

CHOICE AND PRESENTATION INFORMATION FORM FOR MEDI-CAL BENEFITS

See Reverse For Privacy Information Practice Act Notification

RECTIONS: *Please fill in the following information about your health care decision. REMEMBER, a choice should be made for each ember of the family for whom you are applying. If you choose to enroll in a Medi-Cal Health Maintenance Organization (HMO/PHP), check e box labeled HMO.*
you choose a Medi-Cal monthly sticker card, check the box labeled CARD.

C

O THE STATE DEPARTMENT OF HEALTH SERVICES: I have made a choice between receiving a Medi-Cal monthly sticker card and rolling in a Medi-Cal Health Maintenance Organization (HMO/PHP). If I (we) are eligible for Medi-Cal, I wish to receive health care benefits r myself and the family members for whom I am authorized to sign as I have indicated in the box below:

. NAME (Please Print) Last	First	Middle	2. Relation To You:	3. Decision Check One HMO	CARD	4. MEDI-CAL NUMBER	5. BIRTHDATE Mo. Day Year	6. SEX F=Female M=Male
2.			Self					
3.								
4.								
5.								
6.								
7.								
8.								

F YOU HAVE CHOSEN AN HMO/PHP, CHECK THE BOX BY THE PLAN'S NAME AND TELL US OW YOU WANT TO BE CONTACTED:

7. ☐ California Medical Group ☐ CompreCare
☐ Kaiser ☐ Wetts Health Plan

8. Contact me . . . . . 1) ☐ At home
2) ☐ By phone

9. Do you have any other Health Insurance? 1) ☐ Yes 2) ☐ No
Company: _____

PLEASE ANSWER THESE QUESTIONS ABOUT YOUR DECISION:

10. Was your decision the same for all members of your family? . . . . . 1) ☐ Yes 2) ☐ No

If you marked no, why was it different for some members?

_____

11. In making your decision, did you think health care in an HMO/PHP would be . . . .
Better than what you receive now . . . . . 1) ☐
About the same as you receive now . . . . . 2) ☐
Not as good as you receive now . . . . . 3) ☐

PRINT YOUR NAME AND ADDRESS BELOW:

Last	First	Middle	Street Number	Street/Road	City
Sign Name		Date	County	Zip	Phone Number

COUNTY/PROJECT USE ONLY BELOW THIS LINE

1. Office (Site Location):
1) ☐ Pittsburg 2) ☐ Richmond
3) ☐ Oakland 4) ☐ Sacramento Co.
5) ☐ East Valley 6) ☐ Florence
7) ☐ Orange 8) ☐

2A. Type of Case:
1) ☐ Intake 2) ☐ Re-evaluation
3) ☐ Aid Code Change 4) ☐ Other

2B. Family Case Number: _____

3. Has client received aid in the last 6 months?
1) ☐ Yes 2) ☐ No

4A. Was printed material received by client?
1) ☐ In Advance 2) ☐ Day of Presentation

4B. Did client report reading the material?
1) ☐ Yes 2) ☐ No

5. Did the client require a translator to understand the written or oral presentations?
1) ☐ Yes 2) ☐ No

6. Date of Presentation: ___ ___ ___ (Mo. Day Year)

7. Presentation Setting:
1) ☐ Individual Presentation
2) ☐ Group 3) ☐ Couple 4) ☐ Other

8. Type of Presentation:
1) ☐ Printed Material 2) ☐ EW
3) ☐ HMO Rep 4) ☐ AV (Film)
5) ☐ State Worker 6) ☐ None
If none, explain: _____

ITEMS 9–13, COUNTY, STATE, HMO REP PRESENTATIONS ONLY:

9. Presentation Started ___ : ___ am pm

10. Presentation Ended ___ : ___ am pm

11. Total Presentation Time (In Min.) . . . . . ___ ___

12. Total County EW Time (In Min.) . . . . . ___ ___

13. Total County Clerical Time . . . . . ___ ___

14. Presentation made by: _____

REFERRAL INFORMATION FORM (RIF)

1. Referral Number:

2. Referral's Name: (Last, First, Middle)

3. Referral's Medi-Cal Number:

4. Referral's Address (House Number, Street or Road)

(City) (County)

5. Zip

5. Referral's Phone Number:

6. Date Sent to Plan:

7. Date RIF returned to PHRED:

Name of Plan

To Plan: The above person has indicated that he/she wishes to enroll after receiving a presentation and/or information in the local Social Services Office.

8. Please contact this person within: (Days)

9. And return this form to PHRED by: Month Day Year

DESCRIBE THE FIRST CONTACT:

0. Date: (Month, Day, Year)

1. Method of Contact:
1) ☐ Phone 2) ☐ Mail
3) ☐ Home 4) ☐ Walk-in

2. Results of first contact:
1) ☐ Verified Enrollee 2) ☐ Enrolled Other Plan
3) ☐ No Contact 4) ☐ Decision Pending
5) ☐ Stay on Regular Medi-Cal 6) ☐ Other: _____

13. How many persons enrolled? (Enter number)

14. Does this represent the referral's total family?
1) ☐ Yes 2) ☐ No

15. How many not enrolled?

16. Explain nonenrolling family members (if any) _____

17. How many attempts were made before the individual was contacted? (Enter number)

IF MORE THAN ONE CONTACT, DESCRIBE THE LAST:

18. Date: (Month, Day, Year)

19. Method of Contact:
1) ☐ Phone 2) ☐ Mail
3) ☐ Home 4) ☐ Walk-in

20. Results of Last Contact:
1) ☐ Verified Enrollee 2) ☐ Enrolled Other Plan
3) ☐ No Contact 4) ☐ Decision Pending
5) ☐ Stay on Regular Medi-Cal 6) ☐ Other: _____

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-Instructional Guide-
REFERRAL INFORMATION FORM

This document will be completed by PHRED/plan staff for all persons wishing to enroll from the Social Service Office.

The following account is an item by item description of the data needed for each question on the RIF. Responsibility for each step is indicated in parenthesis at the beginning of the descriptions of each item.

1. REFERRAL NUMBER - (PHRED) PHRED staff will indicate the log number given to each individual. This is a 6-digit code initiated for a client on the BIF. (See General Specifications.)

2. REFERRAL NAME - (PHRED/PLAN) PHRED staff will indicate the respondent's name if referring the individual to the plan; the PLAN will indicate the respondent's name if individual is self-referred. The name should be printed in the following order: last, first, middle with a space skipped between last and first and between first and middle.

3. REFERRAL'S MEDI-CAL NUMBER - (PHRED/PLAN) PHRED staff will indicate the respondent's Medi-Cal number if referring the individual to the plan; PLAN will indicate the respondent's Medi-Cal number if individual is self-referred.

4A- REFERRAL'S ADDRESS - (PHRED/PLAN) PHRED staff will indicate the
4B. respondent's address if referring the individual to the plan; PLAN will indicate the respondent's address if individual is self-referred. The address should be filled in as follows: A. the respondent's house number followed by street or road with one space skipped between number and street. If respondent resides in an apartment, apartment number should be entered after street with one space skipped in between, B. the name of the city in which the respondent lives, C. the name of the county in which the respondent lives, D. the respondent's ZIP code.

5. REFERRAL'S PHONE NUMBER - (PHRED/PLAN) PHRED staff will indicate the respondent's phone number if referring the individual to the plan; PLAN will indicate the respondent's phone number if individual is self-referred. Phone number should be entered in the followed order: area code (3 digits), prefix (3 digits), number (4 digits).

6. DATE SENT TO PLAN - (PHRED) PHRED staff will indicate the date the RIF was sent to the plan in the following order: month, day, year. Example: |0|3|2|3|7|9|.

7. DATE RIF RETURNED TO PHRED - (PHRED) PHRED staff should indicate the date the RIF was received by them in the following order: month, day, year.

8. NUMBER OF DAYS TO CONTACT - (PHRED) PHRED staff will indicate the desired number of days the plan has to contact the respondent.

9. RETURN FORM TO PHRED BY - (PHRED) PHRED staff will indicate the date the RIF should be returned to them by the plan in the following order: month, day, year.

10. DATE OF FIRST CONTACT - (PLAN) The plan should indicate the date of first contact with the individual in the following order: month, day, year. Example: April 5, 1979 would be -|0|4|0|5|7|9|.

11. METHOD OF FIRST CONTACT - (PLAN) The plan should indicate the method of first contact with the individual with: 1=phone call, 2=mailed material, 3=home visit, 4=walk-in (respondent walks into plan on own).

12. RESULTS OF FIRST CONTACT - (PLAN) The plan should indicate the results of their first contact with the individual with - 1=verified enrollee, 2=enrolled in another plan, 3=no contact, 4=decision pending, 5=stay on regular Medi-Cal, and 6=other.

13. NUMBER OF PERSONS ENROLLED - (PLAN) The plan should indicate the number of persons enrolled as a direct result of this referral. IF NO PERSONS ENROLL MARK|0|0|. In other cases, indicate the exact number - Example - 6 persons would be|0|6|.

14. REPRESENT ENTIRE FAMILY - (PLAN) The plan should indicate whether or not the number of persons enrolled represents the respondent's entire family. IF NO ONE ENROLLED, MARK NOT APPLICABLE. 1=Yes, 2=No, 3=Not Applicable.

15. NUMBER OF PERSONS NOT ENROLLED - (PLAN) If No (2) on 14, this does not represent the entire family, enter the number not enrolled.

16. EXPLAIN NON-ENROLLING FAMILY MEMBERS - (PLAN) If applicable state reasons for non-enrolling family member(s).

17. NUMBER OF TIMES CONTACTED - (PLAN) The plan should indicate the total times the individual was contacted by them. Example - 4 visits would be |0|4|. See General Specifications for definition of a contact.

NOTE: IF THERE WAS MORE THAN ONE CONTACT, THE PLAN SHOULD FILL IN ITEMS # 17-19, IF NOT, THESE ITEMS SHOULD BE LEFT BLANK. BE SURE NOT TO MARK THE RESPONDENT AS ENROLLING ON BOTH CONTACTS.

18. DATE OF LAST CONTACT - (PLAN) The plan should indicate the date of their last contact with the individual in the following order - month, day, year. Example - April 10, 1979 would be -|0|4|1|0|7|9|.

19. METHOD OF LAST CONTACT - (PLAN) The plan should indicate the method used on their last contact with the individual with - 1=phone call, 2=mailed material, 3=home visit, 4=walk-in (respondent walks into plan, self-referred.

20. RESULTS OF LAST CONTACT - (PLAN) The plan should indicate the results of their last contact with the individual with - 1=verified enrollee, 2=enrolled in another plan, 3=no contact, 4=decision pending, 5=stay on regular Medi-Cal, 6=other. BE SURE NOT TO MARK THE RESPONDENT AS ENROLLING ON BOTH CONTACTS.

ATTACHMENT E-1

PLAN VERIFICATION QUESTIONNAIRE
(PHRED Project Membership Studies)

(for verification by phone)

Statement to applicant: Hello, Mr./Mrs./Ms. _____, this is _____ of _____ Health Plan. I am here to let you know that we are very happy that you have applied for enrollment in our plan and to be sure that you have an opportunity to find out anything else you would like to know about belonging to the health plan. If you don't mind, so that we can both be sure you know everything you should know before you actually use the plan, I'll ask you a few questions first and then you can ask me if there is anything else. Is this all right with you? (I am tape recording this interview so that the State Department of Health Services can verify that you do want to enroll. Is this all right with you?_____).

First, I need to be sure that we have all the facts straight. Your current address and telephone number are _____ and _____. Your Medi-Cal number is _____. (If applicable:) You also enrolled some members of your family: The names and Medi-Cal numbers I have are: _____, _____; _____, _____; _____, _____; etc.... Now I need to check a few details about your application and your eligibility. Did you get a regular Medi-Cal card this month? _____ According to our records you choose the plan by mail or at the _____ Social Services office on _____. Is this correct? _____

We need to be sure that no one in your home has applied for enrollment or been enrolled in this or any other Prepaid Health Plan this year so that we won't have you enrolled in two plans at once. (pause for response)

Now, I'd like to go over some important information about your enrollment. If there is something you don't understand, please stop me, and we'll talk about it. First, do you understand that you have applied for enrollment in _____ health plan? and that your enrollment must be reviewed by the State Department of Health Services? _____ If you become/continue to be eligible for Medi-Cal, it will be effective and you will be a member of our plan within about _____ days. (pause) You will know when you are offically enrolled because you will receive a special identification card instead of your regular monthly Medi-Cal card. Do you have any questions about not getting your regular card any more when you are a plan member?

It is really important for you to carry your new identification card with you at all times in case you need emergency services, because you should present this card whenever you have an appointment or need any care or treatment. I hope that you clearly understand that when you are a member of our plan you will no longer be able to visit your current doctor or dentist (unless they work for our plan). Does this cause any problems for you? _____ Are you

now receiving medical or dental care that you feel could only be continued by your current doctor or dentist and could not be transferred to one of our providers? _____ You should remember if you receive care from a doctor, dentist, or hospital that is not with our health plan, except in an emergency, you will have to pay for these bills yourself. When you become a member, Medi-Cal will pay us to provide all the care you need and you must use our services because they are already paid for you.

Incidentally, do you have a way to get health care until you receive your _____ _____ (PHP) card? ____ If you don't have a doctor, or need some other care, you are welcome to come to our (health center, clinic, offices, etc.) with your Medi-Cal card. You should bring the reminder slip you got at the Social Services office/the letter you got from the State Department of Health Services after you enrolled by mail/so our receptionist will know you are going to be a member.

It would be a good idea for you to come to our health center (clinic, offices, etc.) anyway to see what we are like during the next month or so because the first 30 days after your enrollment is effective is a period during which you can disenroll for any reason. After that, do you know what to do if you have a problem with the health plan and think you might want to disenroll? ____ (confirm) You may request disenrollment or make a complaint to our Grievance Coordinator. If we can't please you, your disenrollment request will be sent to the State Department of Health Services. The whole process usually takes about 45 days but could take longer for the State's computer to handle.

I hope you understand that joining our plan is voluntary and completely your choice. It does not affect your monthly check, food stamps, or your right to medical benefits. (pause for response) _____

Do you have any questions about your enrollment application and the things we have just discussed? _____ You will be getting more information about our services in the mail as soon as your membership is processed.

Let's see. You will be getting care at our _____ health center, clinic, office, etc.). The regular office hours there are _____. Is that convenient for you? ____ Will you have any trouble getting there on your own? ____ You do understand that we do/do not provide transportation for routine or non-emergency care? (pause) _____

(Note to plan: Add other plan-specific use information--e.g., appointment-making, child care, CHDP, etc.)

_____

_____

_____

_____

_____

_____

_____

_____

You should understand what to do in an emergency. (Explain, ask for understanding) _____

_____

_____

_____

That's everything I wanted to check over with you. Do you have any questions? (Note) _____

_____

_____

_____

Verifier _____

Date _____

ATTACHMENT F

Form letter to those without phones or not answering phone

Dear:

On (date), in the (social services office name), you decided to enroll in (plan name). We're very glad you did and look forward to serving you and your family. Before we can, however, there is another step in the enrollment process which we have to complete with you. We need to talk with you over the phone and give you some more information about how our plan works and be sure that you understand what it means to be a member of (plan name).

Because we don't have a telephone number for you (or because we have not been able to reach you by phone), we need to ask you to call us, so that we can continue processing your enrollment. As soon as possible, please call me (or name of verifier-orienter), at (plan number). If you prefer, you may come into our office at (_____) and ask for me (me or whomever) and we'll go through the information together.

We look forward to hearing from you soon so that you can become a member of (plan name). If you already have a Medi-Cal card, remember that you can use it at our plan until your enrollment is in effect and you have one of our membership cards. Please bring this letter with you if you do come in with your card so that our staff will know you have decided to enroll.

Sincerely,

Plan Representative

ATTACHMENT E-2

PLAN VERIFICATION QUESTIONNAIRE
(PHRED Project Membership Studies)

(for in-home or in-office verification)

Statement to applicant: Hello, Mr./Mrs./Ms. _____, this is _____ of _____ Health Plan. I am here to let you know that we are very happy that you have applied for enrollment in our plan and to be sure that you have an opportunity to find out anything else you would like to know about belonging to the health plan. If you don't mind, so that we can both be sure you know everything you should know before you actually use the plan, I'll ask you a few questions first and then you can ask me if there is anything else. Is this all right with you? (I am tape recording this interview so that the State Department of Health Services can verify that you do want to enroll. Is this all right with you?_____).

First, I need to be sure that we have all the facts straight. Your current address and telephone number are _____ and _____. Your Medi-Cal number is _____. (If applicable:) You also enrolled some members of your family: The names and Medi-Cal numbers I have are: _____, _____; _____, _____; _____, _____; etc.... Now I need to check a few details about your application and your eligibility. Did you get a regular Medi-Cal card this month? _____ According to our records you choose the plan by mail/or at the _____ Social Services office on _____. Is this correct? _____

We need to be sure that no one in your home has applied for enrollment or been enrolled in this or any other Prepaid Health Plan this year so that we won't have you enrolled in two plans at once. (pause for response)

Now, I'd like to go over some important information about your enrollment. If there is something you don't understand, please stop me, and we'll talk about it. First, do you understand that you have applied for enrollment in _____ health plan? and that your enrollment must be reviewed by the State Department of Health Services? _____ If you become/continue to be eligible for Medi-Cal, it will be effective and you will be a member of our plan within about _____ days. (pause) You will know when you are offically enrolled because you will receive a special identification card instead of your regular monthly Medi-Cal card. Do you have any questions about not getting your regular card any more when you are a plan member?

It is really important for you to carry your new identification card with you at all times in case you need emergency services, because you should present this card whenever you have an appointment or need any care or treatment. I hope that you clearly understand that when you are a member of our plan you will no longer be able to visit your current doctor or dentist (unless they work for our plan). Does this cause any problems for you? _____ Are you

now receiving medical or dental care that you feel could only be continued by your current doctor or dentist and could not be transferred to one of our providers? _____ You should remember if you receive care from a doctor, dentist, or hospital that is not with our health plan, except in an emergency, you will have to pay for these bills yourself. When you become a member, Medi-Cal will pay us to provide all the care you need and you must use our services because they are already paid for you.

Incidentally, do you have a way to get health care until you receive your _____ (PHP) card? ____ If you don't have a doctor, or need some other care, you are welcome to come to our (health center, clinic, offices, etc.) with your Medi-Cal card. You should bring the reminder slip you got at the Social Services office/the letter you got from the State Department of Health Services after you enrolled by mail/so our receptionist will know you are going to be a member.

It would be a good idea for you to come to our health center (clinic, offices, etc.) anyway to see what we are like during the next month or so because the first 30 days after your enrollment is effective is a period during which you can disenroll for any reason. After that, do you know what to do if you have a problem with the health plan and think you might want to disenroll? _____ (confirm) You may request disenrollment or make a complaint to our Grievance Coordinator. If we can't please you, your disenrollment request will be sent to the State Department of Health Services. The whole process usually takes about 45 days but could take longer for the State's computer to handle.

I hope you understand that joining our plan is voluntary and completely your choice. It does not affect your monthly check, food stamps, or your right to medical benefits. (pause for response) _____

Do you have any questions about your enrollment application and the things we have just discussed? _____ You will be getting more information about our services in the mail as soon as your membership is processed.

Let's see. You will be getting care at our _____ health center, clinic, office, etc.). The regular office hours there are _____. Is that convenient for you? ____ Will you have any trouble getting there on your own? ____ You do understand that we do/do not provide transportation for routine or non-emergency care? (pause) _____

(Note to plan: Add other plan-specific use information--e.g., appointment-making, child care, CHDP, etc.)

_____

_____

_____

_____

_____

_____

_____

_____

You should understand what to do in an emergency. (Explain, ask for understanding) _____

That's everything I wanted to check over with you. Do you have any questions? (Note) _____

Verifier _____ .

Date _____

ATTACHMENT B

Marketing Costs--Report for PHRED Demonstration

Plan _____

Method _____

Dates _____

I. Direct Costs

A. Direct Labor

1. All Enrollers $ _____
2. Clerical Staff $ _____
3. Verification Staff $ _____
4. Supervisory Staff $ _____
5. Marketing Manager $ _____

B. Payroll Additives (% of DL) $ _____

C. Mileage $ _____

D. Other Direct Costs (specify) $ _____

1. _____ $ _____
2. _____ $ _____
3. _____ $ _____

Total Direct Costs $ _____

II. Time Spent on PHRED

	Total Hours	PHRED Hours
A. All Enrollers	_____	_____
B. Clerical Staff	_____	_____
C. Verification Staff	_____	_____
D. Supervisory Staff	_____	_____
E. Marketing Manager	_____	_____

III. Indirect Costs (total monthly)

A. Materials (Printed) $ _____

B. Advertising Costs $ _____

C. Equipment and Other Supplies $ _____

D. Telephone $ _____

E. Utilities $ _____

F. Rent $ _____

G. Depreciation $ _____

H. Other (Specify) $ _____

1. _____

2. _____

3. _____

Total Indirect Costs $ _____

Marketing Costs--Report for PHRED Demonstration

Plan _____

Method _____

Dates _____

I. Direct Costs

A. Direct Labor

1. All Enrollers $ _____
2. Clerical Staff $ _____
3. Verification Staff $ _____
4. Supervisory Staff $ _____
5. Marketing Manager $ _____

B. Payroll Additives (% of DL) $ _____

C. Mileage $ _____

D. Other Direct Costs (specify) $ _____

1. _____ $ _____
2. _____ $ _____
3. _____ $ _____

Total Direct Costs $ _____

II. Time Spent on PHRED

	Total Hours	PHRED Hours
A. All Enrollers	_____	_____
B. Clerical Staff	_____	_____
C. Verification Staff	_____	_____
D. Supervisory Staff	_____	_____
E. Marketing Manager	_____	_____

III. Indirect Costs (total monthly)

A. Materials (Printed) $ _____

B. Advertising Costs $ _____

C. Equipment and Other Supplies $ _____

D. Telephone $ _____

E. Utilities $ _____

F. Rent $ _____

G. Depreciation $ _____

H. Other (Specify) $ _____

1. _____

2. _____

3. _____

Total Indirect Costs $ _____

Instructions for Marketing Costs Report

I. Purpose of Report

The purpose of the Marketing Costs Report for the PHRED demonstrations is to determine accurately that portion of costs borne by the prepaid health plan during each method demonstrated by the PHRED Project. Some methods require little effort (and, therefore, litle cost) on the part of the plan while others require more effort and more expense. The information will be integrated with state/county cost information and encounter data in the evaluation of each method.

II. When a Report is Required

At the end of each demonstrated method, the report must be completed by each plan for each welfare office site with which the plan is involved with Therefore, it would be wise to keep aggregate data during the method being demonstrated (such as, hours devoted to PHRED) to make the report completion easier.

III. Direct Costs - Completing the Form

A. The direct costs reported should reflect the total costs expended by that portion of the marketing/verification staff devoted to the Medi-Cal project during the period under consideration.

B. Example: If a plan has one full-time marketing manager, one verifier, two enrollers, and three clerical staff assigned to the marketing/ verification of Medi-Cal clients and the method being demonstrated is a 10-week period; the plan should determine the monthly costs for each category of personnel and multiply that by 2.5 (10 weeks) to complete the form.

C. Personnel who work only part-time should be included with appropriate adjustments to show accurate payment for work accomplished.

IV. Time Spent - Completing the Form

A. The key to accurately completing the Marketing Cost Report is to keep close watch on the hours expended by plan staff for the PHRED Project. All cost information that is reported (Parts I and III) would normally be accumulated for the Plan's annual and quarterly fiscal reporting, but the hours spent performing PHRED-related activities require a little extra effort. The hours reported will then be used to determine percentages of time expended on PHRED activities and then converted to percentages of costs.

B. The total hours for each category listed should be equal to the amount of time that marketing/verification staff was paid for as reported in Part IA. (Therefore, if the plan had a loss of 25 hours due to sick leave during the 10-week period for which it was reporting but the plan pays for that sick leave, the 25 hours would be included in the total hours, since the pay factor was included in Part IA).

C. The PHRED hours for each category listed should equal the actual hours spent by plan personnel in performing PHRED-related activities.

V. Indirect Costs - Completing the Form

A. Recognizing that some indirect costs fluctuate during the course of the year (such as the cost of reprinting material stock), it appears that the fairest method for distributing these costs across the time frame for the PHRED Project demonstrations is to take a percentage for PHRED of the average monthly indirect costs accrued over a one-year period. Consequently, you are to fill in this portion of the form with a monthly average for the Medi-Cal administrative cost component based on the previous one year experience.

B. Example 1

Plan X is currently paying $400 a month for administrative offices as overhead for their Medi-Cal clients. The plan has paid this amount for the past six months; prior to that, the rent for the Medi-Cal portion was $350 a month. Looking back over the past 12 months, we determine that the rent had remained at $350 for six months then rose to $400 for the next six months. The average rent for this 12-month period for the Medi-Cal portion therefore, is $375. This amount should be entered on the form.

C. Example 2

Plan X has decided to do a one-time mailing to a target area to announce the opening of a new clinic. The mailing is directed to resident addresses only although the plan knows that there is a 45 percent concentration of Medi-Cal clients in the target area. The plan first needs to determine the total cost of the mailing (printing, postage, art work, return referrals, etc). Since in this instance it would be difficult to segregate out the Medi-Cal-only costs, divide that by 12 to spread it out over a one-year period and enter the amount under III(B) Advertising Costs.

Rockridge

NCIMS Participation Schedule

June 4 to August 10, 1979	Prepaid Health Plan Representative Method. Plan must supply one representative to give presentation at the North Oakland Welfare Office at 4501 Broadway, Oakland.
August 13 to September 7, 1979	Mailing Method. Plan cannot market in any ZIP code served by the North Oakland Welfare Office. (ZIP code listing is on next page).
September 10 to November 2, 1979	Assessment of Current Method. Plan must market in the ZIP codes served by the North Oakland Welfare Office and report encounter and cost data for such marketing.
November 5, 1979 to January 11, 1980	Eligibility Worker Method. Plan may continue marketing in the ZIP code areas served by the North Oakland Office but cannot work outside the office.
January 14 to March 21, 1980	State Representative Method. Plan may market in the ZIP code area surrounding the welfare office but not near the office itself.
March 24 to May 30, 1980	Film Method. Plan may continue marketing in the ZIP code area served by the North Oakland Welfare Office.

ZIP Codes Served by the North Oakland Office

94708	94702
94704	94710
94611	94625
94618	94601
94705	94609
94709	94608
94026	94610
94602	94612
94720	94607
94707	94501
94706	94703

Contra Costa Key Plan

Contra Costa County Key Plan
Participation Schedule

April 16 to June 8, 1979	Current Method. Plan continues business as usual.
June 11 to August 17, 1979	Key Plan Representative Method. Key Plan Representative gives the PHRED prepared presentation.
June 20 to September 14, 1979	Mailing Method. PHRED Project will direct mail to all eligible Medi-Cal beneficiaries residing in ZIP Codes serviced by the welfare demonstration office. The plan cannot market to redetermination clients during this period.
September 17 to November 23, 1979	PHRED Representative Method. PHRED Representative gives the prepared presentation.
November 26 to February 1, 1980	Film Method. A 10 minute film is shown of the prepared presentation.
February 4 to April 11, 1980	County Representative Method. County Representative gives the PHRED prepared presentation.

ZIP Codes Served by the Pittsburg Office

94565

94509

94513

94514

94561

94511

Contra Costa County Key Plan
Participation Schedule
(Richmond Office)

April 16 to June 22, 1979	County Representative Method. County Representative gives the PHRED prepared presentation.
June 25 to August 17, 1979	Current Method. Plan continues business as usual.
August 20 to October 26, 1979	Film Method. A 10 minute film is shown of the prepared presentation.
October 29 to January 4, 1980	PHRED Representative Method. PHRED Representative gives the PHRED prepared presentation.
January 7 to March 14, 1980	Key Plan Representative Method. Key Plan Representative gives the PHRED prepared presentation.
March 17 to April 11, 1980	Mailing Method. PHRED Project will direct mail to all eligible Medi-Cal beneficiaries residing in ZIP Codes serviced by the welfare demonstration office. The plan cannot market to redetermination clients during this period.

ZIP Codes Served by the Richmond Office

94805

94530

94707

94804

94806

94801

Healthcare

Schedule for Sacramento County
PHRED Project

June 4 to August 10, 1979	State representative method.
August 13 to September 7, 1979	Mailing method. Plan must refrain from marketing in the ZIP Codes served by the welfare office.
September 10 to November 16, 1979	PHP representative method. Plan must station a representative in the welfare office at 4829 Folsom Blvd. Plan may resume regular marketing method.
November 19, 1979 to January 4, 1980	Current method. Plan must gather cost and encounter data in those ZIP Codes served by the welfare office at 4829 Folsom Blvd.
January 7 to March 14, 1980	County worker method.
March 17 to May 30, 1980	Film method. Plan may continue regular marketing method.

ZIP Codes Served by the
Demonstration Site Welfare Office

95814

95818

95819

95825

95826

95827

Kaiser

CMG

N. E. Valley

East Valley District

June 4 to August 10, 1979	State representative method. Plan must stay away from district office at 14545 Lanark Street but may market in the surrounding area.
August 13 to October 19, 1979	PHP representative method. Plan must supply a marketing representative to be in the welfare office at 14545 Lanark Street per schedule (to be developed). Plan must stay away from welfare office but may market in the surrounding area.
October 22 to December 14, 1979	Current marketing method. Plan must market in the area surrounding the welfare office and report cost and encounter data for representatives working that area. At least 200 contacts must be made with eligible beneficiaries.
December 17, 1979 to February 22, 1980	Eligibility worker method. Plan must stay away from district office at 14545 Lanark Street but may market in the surrounding area.
February 25 to March 21, 1980	Mailing method. Plan must not market in the ZIP Code area served by the welfare office at 14545 Lanark Street.
March 24 to May 30, 1980	Film method. Plan must stay away from district office at 14545 Lanark Street but may market in surrounding area.

ZIP Codes Served by the
East Valley District (Panorama City)

91330	91407	91605
91331	91408	91606
91341	91412	91607
91401	91601	
91402	91602	
91404	91603	
91405	91604	

HMO Concepts

Westminster Office (Orange County)

May 14 to July 21, 1979	Eligibility Worker Method. Plan must stay away from District Office at 9191 Westminster Ave., Garden Grove but may market in the surrounding area.
July 23 to August 17, 1979	Mailing Method. Plan must not market in the zip code area served by the Welfare Office at 9191 Westminster Ave.
August 20 to October 12, 1979	Current Marketing Method. Plan must market in the area surrounding the Welfare Office and report cost and encounter data for representatives working that area. At least 200 contacts must be made with eligible beneficiaries.
October 15 to December 21, 1979	Film Method. Plan must stay away from District Office at 9191 Westminster Ave., but may market in surrounding area.
December 24, 1979 to February 29, 1980	PHP Representative Method. Plan must supply a marketing representative to be in the Welfare Office at 9191 Westminster Ave., two days each week. (Schedule to be developed). Plan must stay away from Welfare Office but may market in the surrounding area.
March 3, 1980 to May 9, 1980	State Representative Method. Plan must stay away from District office at 9191 Westminster Ave., but may market in the surrounding area.

ZIP Codes Served by West District Office

90720
90740
90630
90650
92640
92641
92642
92804
92643
92644
92645
92646
92647
92649
92683

Watts

Florence Office (Los Angeles)

June 4 to July 27, 1979	Current marketing method. Plan must market in the area surrounding the welfare office and report cost and encounter data for representatives working that area. At least 200 contacts must be made with eligible beneficiaries.
July 30 to October 5, 1979	State representative method. Plan must stay away from district office at 1740 Gage Street but may market in the surrounding area.
October 8 to December 14, 1979	PHP representative method. Plan must supply a marketing representative to be in the welfare office at 1740 East Gage Street per schedule (to be developed). Plan must stay away from welfare office but may market in the surrounding area.
December 17, 1979 to January 11, 1980	Mailing method. Plan must not market in the ZIP Code area served by the welfare office at 1740 East Gage Street.
January 14 to March 21, 1980	Film method. Plan must stay away from district office at 1740 East Gate Street but may market in surrounding area.
March 24 to May 30, 1980	Eligibility worker method. Plan must stay away from district office at 1740 Gage Street but may market in the surrounding area.

ZIP Codes Served by the
Florence District Office

90001

90002

90003

APPENDIX F

Reports of Pretests of Instruments

Los Angeles Mailing
Technical Support Group Working Document

Prepared for Membership Studies, PHRED Project
Analyzed by: Barbara Curbow
Assisted by: Susan Ross Brown

September 11, 1978
Draft #1

The attached copy of the "Los Angeles Mailing" paper is being retained by the PHRED Project in working draft form. The reasons not to finalize this product are twofold. First, the original analysis, as represented here, contains a group of subjects (those persons self-initiating contact with the plans during this period, who did not receive the mailing materials--less than ten percent) which should be considered as a separate sample. The existence of this group of persons creates a systematic error which could only be eliminated by a thorough reanalysis. This reanalysis does not fit within the time allocations of the Project. Second, while the data do not lend themselves to formal presentation at this time, they are clear enough to reflect general trends. These trends have already been acknowledged and implemented in subsequent PHRED mailings. Thus the original purpose of the Los Angeles Mailing, to act as a pretest of methodology, has been served.

Los Angeles Medi-Cal Alternative Mailing
Summary of Results and Findings

BACKGROUND INFORMATION

Objectives:

To pretest mailed information as a means to fulfill the Department of Health Services' responsibility to advise Medi-Cal beneficiaries of their right to select a health care system from the fee-for-service or prepaid Medi-Cal alternatives. Secondarily, to evaluate this method of informing beneficiaries about PHPs as an alternative to door-to-door solicitation of enrollments.

Mailing Package (attached):

1. Cover letter from Bruce Yarwood, Deputy Director, Medical Assistance.

2. Information comparing fee-for-service system and prepaid health plans, plus information on PHPs available in the ZIP code. Because of differences in the service areas of the local plans, the information was prepared in two lots; one including Maxi-Care, and one without that alternative. (The following plans serve most or all of the ZIP codes: Maxi-Care, South Los Angeles Community, California Medical Group, and Watts.)

3. Card to return to Department asking for more information from plan (or plans) in area. Beneficiaries could also indicate that they wished to continue receiving a fee-for-service card.

Referral Procedure:

DOH received cards returned by interested beneficiaries, logged them in and sent referral information to the PHP. PHP contacted those requesting more information and reported contacts and outcome to DOH.

Date of Mailing:

First week of January 1978.

Evaluation:

Analysis was conducted by PHRED staff, a detailed presentation was drafted and is attached.

Los Angeles Medi-Cal Information Mailing

SUMMARY DATA

I. RESPONSE RATE

		Total	Percent
1.	Number of information packets mailed.	66,000	100.0
	A. Packets mailed in Lot I (with Maxi-Care).	29,267	44.3
	B. Packets mailed in Lot II (without Maxi-Care).	36,733	55.7
2.	Number of packets returned unopened.	1,574	2.4
3.	Number of packets delivered.	64,426	97.6
4.	Number of persons indicating a choice for fee-for-service.	6,892	10.6
5.	Number of persons seeking more information about a PHP	792	1.2
6.	Total Response	7,684	11.6
7.	Breakdown of those requesting PHP information	792	100.0
	A. Distinct individuals who were contacted by the plans (referred by State).	318	40.2
	B. Distinct individuals who referred themselves to the plans as a result of the mailer.	154	19.5
	C. Persons returning cards for whom Medi-Cal numbers could not be found (not included in analysis.	35*	4.4
	D. Persons returning cards who were either referred to the plans after analysis or who were referred to the plans twice (not included in analysis).	285*	35.9
	E. Total number of distinct persons resulting from the mailer who wanted more information.	792	100.0
8.	Number of possible contacts (referred and self-initiated.	753	100.0

*Approximate count

	Total	Percent
9. Distinct individuals responding to mailer.	472	100.0

II. POPULATION CHARACTERISTICS**

1. Number of persons requesting information about:		
A. One plan.	364	77.1
B. Two plans.	40	8.5
C. Three plans.	37	7.8
D. Four plans.	31	6.6
2. English/Spanish card usage (by number of referrals):		
A. English	349	46.4
B. Spanish	55	7.3
C. Unknown (missing data and/or self-referrred)	349	46.2
3. Percent of referrals made to each plan		
A. Plan 1 (Maxi-Care)	182	24.2
B. Plan 2 (SLACHP)	161	21.4
C. Plan 3 (Watts)	109	14.5
D. Plan 4 (CMG)	301	40.0

4. Types of contacts made on each encounter (by number of referrals).

	First Contact		Last Contact	
	Total	Percent	Total	Percent
A. Home visit	276	36.7	535	71.1
B. Phone	301	40.8	150	19.9
C. Mail	0	0.0	0	0
D. Walk-in	59	7.8	37	4.9
E. Unknown	116	15.4	30	4.0

Note: Unknown category may indicate that no contact was made.

*Population analysis erroneously includes 71 individuals whose self-referral status is unclear (those whose self-referral may not have been motivated by the mailer).

5. Number of referrals from each aid code:

	Total	Percent	Population in Area*
A. OAS	262	34.7	19.4
B. AB	10	1.3	.9
C. AFDC	316	42.0	54.5
D. ATD	163	21.6	25.2
E. Unknown	2	.3	--

III. OUTCOMES

1. Number of encounters resulting in a verified enrollment as reported by the plans for each aid code:

	Total	Percent
A. OAS	122	26.4
B. AB	5	1.1
C. AFDC	236	51.1
D. ATD	97	21.0
	460	99.6

2. Number of actual enrollments reported in each aid code:**

A. OAS	124	17.9
B. AB	5	.7
C. AFDC	463	66.7
D. ATD	100	14.4
	692	99.7

*Percent weighed by totals from each lot.

**Due to various coding errors and incomplete data, these reported figures are not accurate. The full report will explain why it is not possible to obtain a precise count of persons enrolled. The actual total is greater by an indeterminate number.

IV. MAJOR FINDINGS

1. Although there was a heavier response from the "adult" aid codes, a lower proportion actually enrolled.**

	Number of Referrals		Number of Enrollments	
	Total	Percent	Total	Percent
A. OAS	262	34.7	124	17.9
B. AB	10	1.3	5	.7
C. AFDC	316	42.0	463	66.7
D. ATD	163	21.6	100	14.4
E. Unknown	2	.03	--	--

2. The Spanish version card was not used by many respondents--only 7.3 percent of the total referrals.

3. Although a greater proportion of respondents preferred a telephone contact, the plans tended to pay home visits:

Respondents' Choice

	Total	Percent
A. Home visit	142	18.9
B. Phone	280	37.3
C. Self-initiated (walk-in)	214	28.5
D. No Choice	70	9.3
E. Error	35	6.0

Plan Practice

	First Contact		Last Contact	
	Total	Percent	Total	Percent
A. Home visit	276	36.7	535	71.1
B. Phone	301	40.8	150	19.9
C. Mail	0	0.0	0	0
D. Walk-in	59	7.8	37	4.9
E. Unknown	116	15.4	30	4.0

**Due to various coding errors and incomplete data, these reported figures are not accurate. The full report will explain why it is not possible to obtain a precise count of persons enrolled. The actual total is greater by an indeterminate number.

INTRODUCTION

The Los Angeles Mailing was conducted by the Membership Studies component of PHRED as a pretest for future marketing and enrollment projects. After an initial examination of the returns indicated that the amount of data received would be of sufficient volume to warrant computer analysis, the Technical Support Group became involved. It was hoped that technical methods developed for the mailing might be generalized to future Membership projects. General Services was contracted to assist and train Technical Support members in the computer processing necessary for the job. Thus, the analysis team had three principal players, Membership Studies, Technical Support and General Services.

The Technical Support Group worked on four main areas in the project: 1) defining data output needs; 2) preparing the data for computer entry; 3) execution of computer programs to generate tables for analysis; and 4) review and compilation of data findings. These areas will be discussed in this paper and in attached appendices.

Defining the Data Output Needs

The first task undertaken by the Technical Support Group was to define the data output needs in a structured manner which would determine the required computations. This involved isolating pertinent questions that might be answered from the available data. (See Appendix ..) This was a relatively straightforward activity as Membership Studies had previously analyzed similar data from their Santa Clara Mailing. It was found that most of the questions that needed to be answered were readily obtainable through the use of a computer package at Benetech. Some additional needs were met by making modifications to other existing programs.

Preparing Data for Computer Entry

It was originally thought that data could be entered onto the computer directly from the coding sheets filled in by the Plans. After careful consideration the methodology was changed to include a second coding of the information on a form designed specifically for this purpose. There were several reasons for doing this. First, the information on each individual

was in two locations. Some of the needed information was on the cards filled in by the respondents and some was on the coding sheets prepared by the Plans. Thus, computer entry would have been made more difficult by shuffling papers back and forth. Second, additional information regarding Plan coding errors was desired, and it was felt that it would be easier to code this information on a new sheet rather than trying to make room on the old form. Third, not all of the 80 characters on the Plan coding sheets were found to be necessary to the computations. So, for reasons of space, accuracy, economy and convenience, a new coding form was developed. (See Appendix F). Data was recoded by Membership Studies Staff.

Executing Computer Programs for Tables and Analysis

The data was entered by the Technical Support Group staff via the project on-line terminal into the Benetech Computer Center. Statistical routines were specified and executed to process the data from the terminal. The tables which were generated were printed out on the terminal. (See Appendix C for a more detailed description)

Review and Compilation of the Data

As the analysis of the data progressed, many questions arose which were subsidiary to the original output needs. The tables program which was used allowed for the freedom to branch off and examine these additional questions. All of the findings are presented in detail in Appendix D.

In the attached analysis of data there will be a continuous reference to the "study population". This group of data is somewhat amorphous and requires a careful definition. Discounting some individuals for whom Medi-Cal numbers could not be found and a few late returns, the number of records that most of the analysis is based upon is 753. This number represents the total referrals that the Plans obtained under three different methods which were: 1) referrals from the state to the Plans of persons returning their mailer cards and requesting more information; 2) referrals which were self initiated by the individual as a result of

the mailer (i.e. the person may have received the mailer then called the Plan directly instead of filling in the card); and 3) persons who were self referred to the Plan without the benefit of the mailer. The number of unique individuals is 551. Many persons requested information from more than one Plan so the actual number of referrals is larger than the number of individuals. Many of the data elements are missing for substantial groups of persons. This fact might create some confusion to the reader. However, those persons who contacted the Plans under methods 2 and 3 above do not have mailer cards and therefore there is no way of knowing such things as contact preference, errors in cards, English/Spanish card usage, etc. This combined category of referrals numbers approximately 225. In addition, there are another 118 referrals which do not have mailer cards for reason(s) unknown. Thus on some questions, roughly 45% of the responses will be unknown. Membership Studies staff have speculated on the cause(s) of this behavior and they hope to counteract it in future experiments.

There is another factor which must be considered when weighing the data, and that is the coding methodology. As is true with most pilot projects, there was some refinement of coding strategies as the study developed. This flexibility was necessary for future trials of the mailing experiment even though it makes the interpretation of the present data somewhat tricky. As problems arose, the coding mechanisms changed to meet the challenges, and this might have caused confusion to some of the Plans.

In spite of the limitations of the present data, there are some very useful pieces of information that can be gleaned from this project. It is possible to use the findings in at least two ways: 1) as a diagnostic "test run" which will allow for further refinement of the data collection system; and 2) as a preliminary view of what seems to be the most important indicators of respondent enrollment. It is hoped that the positive aspects of the data usage will outweigh the uncertainties.

The analysis of the data has been structured around five central issues:

1. Demographic Characteristics: Are the persons who wanted more information about PHPs different from other persons within the same environment?

2. Preferences: When the individuals and the Plans had to make a choice, what did they decide?

3. Process: What went on in the referral/enrollment cycle? What were the common problems?

4. Time Frames: Did the time intervals affect outcome? How did the Plans compare to each other in reaction times?

5. Outcomes: Which factors seemed to affect the number of persons enrolled?

These issues are discussed in detail in Appendix __; conclusions and suggestions will be offered in the following section.

Conclusions

The productivity of the Los Angeles Mailer may be appraised by two criteria, each of which changes its image of effectiveness. On the one hand, the total response rate may be examined and found to be somewhat low; on the other hand, the rate of contacts resulting in enrollments appears to to be high. There are two levels of screening which occur in the mailing; a mass screening which sorts out all the people who are definitiely not interested in PHPs, and a selective screening of those who are somewhat interested. As a method of enrollment, this screening process may be considered to be very important as it allows the Plans to concentrate their efforts on those persons who are most likely to enroll. Therefore, one must weigh the costs of the initial mass screening against the benefits of being able to identify a pool of prospective enrollees.

One question which stands out in the analysis is, who are the prospective enrollees? From the available data one can conclude that although the OAS and ATD response rate was high, the group most likely to enroll is AFDC. The most widely used card was the English version, with Spanish card usage composing only 7.3% of the total responses. It was found that the Spanish card usage was higher in some zip codes than in others. Perhaps future studies will be able to determine an age/sex component of this picture.

When the respondent were given the opportunity to choose how they would like to be contacted, they overwhelmingly preferred to be phoned. This contrasted with the actual practices of the Plans who reported a high usage of home visits to contact their referrals. There was a slight preference by the Plans to pay home visits to the AFDC respondents. Plan 4, CMG, was the most popular plan when compared on an overall basis of the total response. When the referrals are separated by Lot, it was found that Plan 1, Maxi-Care was chosen most frequently in Lot I.

The error rates by the Plans and the respondents were quite substantial. There seemed to be particular areas which caused problems for each group. The plans made most of their errors in coding the number of persons enrolled. This was probably due to a late change in coding instructions.

Because of the high error rate in this field, it is impossible to get an accurate count of the actual number of persons who were enrolled. Two other fields that seemed to be problematic for the Plans were type of initiation and method of first contact. The errors that were made by the respondents were not as debilitating for the data analysis as those made by the Plans. Although the respondents had high error rates, most were not serious enough to hinder the Plans' ability to contact them. One exception was a frequent omission of Medi-Cal numbers which were needed to identify the respondents' aid codes. This meant that Membership Studies staff had to spend time trying to track aid codes from other sources of information. It appears that these "process" errors may easily be remedied by having more explicit coding instructions for the Plans and by using preprinted labels on the respondents' mail in cards.

The time frames that were involved in this study revealed some interesting information. It was found that the early Plan did get the enrollee. Referrals not made within the first 5 days did not usually result in an enrollment. The analysis of time brought up an issue that had not been addressed previously, that was the existence of "0" day time spans between contacts and between the date of referral and contacts. The number of referrals that reported a "0" time period was so large that it skewed the results towards some unrealistic conclusions. As a result of this, data was analyzed with and without the "0" days.

The defining of outcomes in this study was hampered by some major sources of data errors. These errors became apparent when a cross tabulation was done between results of contacts and number enrolled. There can not be an accurate count of the number of persons enrolled, but some tendencies do exist. The most likely canidate is an AFDC who was visited at home by the Plan after being referred by the state. As far as the rate of enrollees per contact, AFDC produced the highest ratio. Persons who were self referred as a result of the mailer also had a high ratio of enrollees per contact.

It would appear from the analysis of the L.A. Mailing that most of the problems that occurred in the data collection can be isolated and remedied rather easily. There is a need for a more complete and usable coding form for the Plans. This form, along with careful monitoring of coding methodology, should produce more accurate information in the future.

Appendix A

Questions to be Answered From

Los Angeles Mailing

1. Of those persons returning cards, what were their contact method preferences?
2. How many of the respondents filled in their cards properly?
3. Which card errors were made most frequently?
4. What types of coding errors were made by the Plans?
5. What was the Plans' favorite method of contact?
6. Did aid code affect method of contact?
7. How many respondents preferred the Spanish version card?
8. Which plans were most appealing to the respondents?
9. Which type of contact was most effective?
10. Were respondents more likely to enroll if the encounter was self initiated?
11. Did it take more than one contact to secure an enrollment?
12. Were there more errors in the Spanish version cards?
13. How many persons wanted more than one type of contact?
14. How productive was each referral?
15. Did elapsed time affect outcome?
16. What was the average time lapse between card referral and first contact?
17. What was the average time period between first and last contact?
18. What was the median time period betweeen first and last contact?
19. What was the modal time period between first and last contact?
20. What was the relationship between type of contact and outcome?
21. Which zip codes produced the most referrals?

Coding Instructions for L.A. Mailer

Field Number	Field Name	Columns	Size	Coding Instructions
1	Number Sequence	1-4	4	Beginning with 0001, code each individual sequentially. Make sure multipl contact sheets for each individual have the same number.
2	Log Number	5-11	7	Code as it appears on sheet. If a column is blank, leave it blank as the position of the number is important.
3	Record Code	12-16	5	Code as it appears on sheet.
4	Medi-Cal #	17-20	4	Code the first 4 digits as they appear on the sheet.
5	Phone	21	1	Code: 1= No check above phone number (respondent did not choose phone.) 2= Check above phone number (responden chose phone.) 3= Error (respondent chose phone but no check appeared on the referral sheet.)
6	Address	22	1	1= No check above address (respondent did not choose address) 2= Check above address (respondent chose address.) 3= Error (respondent chose address but no check appeared on the reference sheet.)
7	Zip Code	23-27	5	Code as it appears on sheet.
8	First Contact	28-31	4	Code MMDD as it appears on sheet.
9	Initiation	32	1	Code as it appears on sheet (1-3)
10	Method #1	33	1	Code as it appears on sheet (1-4)
11	Results #1	34	1	Code as it appears on sheet (1-6)
12	Last Contact	35-38	4	Code MMDD as it appears on sheet.
13	Number Enrolled	39	1	Code as it appears on sheet (0-9)
14	Method #2	40	1	Code as it appears on sheet (0-4)
15	Results #2	41	1	Code as it appears on sheet (0-6)
16	Initiation Corr.	42	1	Code as it appears in red, leave blank if blank.
17	Method Corr. #1	43	1	Code as it appears in red, leave blank if blank.

Field Number	Field Name	Columns	Size	Coding Instructions
18	Results Corr. #1	44	1	Code as it appears in red, leave blank if blank.
19	Enrolled Corr.	45	1	Code as it appears in red, leave blank if blank.
20	Method Corr. #2	46	1	Code as it appears in red, leave blank if blank.
21	Results Corr. #2	47	1	Code as it appears in red, leave blank if blank.
22	Lot Number	48	1	Code: 1= Lot 1 (4 plans) 2= Lot 2 (3 plans)
23	Eng/Span	49	1	Code: 1= English version card 2= Spanish version card
24	Inconsistent Data	50	1	Code: 1= No error 2= Error
25	Incomplete Data	51	1	Code: 1= No Error 2= Error
26	Too Much Data	52	1	Code: 1= No Error 2= Error

1. Inconsistent Data Errors:
   Stay on Medi-Cal, get more information.
   Printed one name, signed another.
   Requested information but did not choose a plan.
   Checked phone or come but did not choose a plan.

2. Incomplete Data Errors:
   No address or city.
   No zip code.
   No Medi-Cal number.
   No signature.
   No date.

3. Too Much Data:
   Sent message on card.
   More than one name on card.
   More than one Medi-Cal number on card.

I DEMOGRAPHIC

There are three demographic variables that can be examined from the available data, these are aid code mix, zip code and English/Spanish card usage. The first area, aid code mix, is examined in Table I-A which is a comparison between the aid breakdowns for L.A. County and study population referrals. The figures for L.A. County are based upon July 1978 Public Assistance data. It can be seen from Table I-A that the referral aid code percentages vary somewhat from those reported for the entire county, the biggest differences are for OAS and AFDC. The study population OAS category comprised 34.7% of the total referrals while the percentage for the entire county is 14.1%. The reverse seems to have happened for AFDC which accounted for 42.0% of the study referrals and 71.6% of the county eligibles. This trend did not hold up for the number of eligibles enrolled in each aid category as will be demonstrated in Section V of this paper. Table I-B illustrates the same aid code breakdown for the two different zip code groups in this study, Lot 1 and Lot 2. It can be seen that the OAS group in Lot I actually surpassed the AFDC in the number of referrals generated.

Table I-C is a breakdown of all zip codes which were originally used in this study. This table shows the number of mailer packets sent to each zip and the subsequent number of referrals per area. This is not a return rate per se because some of thereferrals were multiple contacts on the same individuals and a substantial number of the contacts were self initiated without prior knowledge of the mailer. Keeping these facts in mind, one can cautiously say that the number of referrals per zip code varied widely with some regions appearing to be more productive than others. Lot I had an overall higher percentage of referrals than did Lot II.

Table I-D lists the original 24 zip codes and the aid code distribution of referrals within each. There were an additional 22 zip codes which were reported in this study. It is possible that the existence of some of these is due to coding errors by one of the many involved parties. These zip codes and their aid distributions are listed in Table I-E. The largest number of referrals came from 90044 which had 104 or 13.8% of the total referrals. The only two other zip codes to produce a substantial percentage

were 90007 with 52 or 6.9% and 90301 with 53 or 7.0% of the total referrals. The other zip codes produced from 6 to 37 referrals each.

The English/Spanish card preference is an indicator of the number of Spanish speaking respondents that were reached by the mailing. This is not an accurate count as it does not reflect the many reasons an individual might have for using one or the other of the cards. It can be seen from Table I-F that there were 55 Spanish version cards which were returned in the study population. This accounts for 7.3% of the total population and 13.6% of the population for which information is available. Tables I-G and H breakdown the zip codes by English/Spanish card preference and establishes that certain areas reflect a higher need for materials in Spanish than do other regions. The percentages for Spanish version card usage ranged from 30.4% in 90006 to 0.0% in many areas.

I Demographic

I D

	LOT I REAL POPULATION		LOT I STUDY ** POPULATION		LOT II REAL POPULATION		LOT II STUDY ** POPULATION	
CAS	5399	15.45	146	39.25	—	20.18*	104	31.42
AB	238	.81	1	.27	—	.97*	9	2.72
AFDC	16,860	57.61	130	34.95	—	52.02*	161	48.64
ATD	6770	23.13	95	25.58	—	26.83*	57	17.22
TOTAL	29,367	100%	372	100	36,733	100	331	100

— actual count
* approximated
** number of referrals

	Adcate, Mix Public Assist	%	Study Population Total Referrals	%
CAS	118,665	14.1	216	34.7
AB	4288	.5	10	1.3
AFDC	602,197	71.6	316	42.0
ATD	115,981	13.8	163	21.6
TOTAL	841,131	100	753	100

Zip Code	Number of Referrals	Number of Returns	Percent of Referrals
90049	10277	104	1.00
90077	[illegible]	47	0.73
[illegible]	2038	20	0.96
90249	996	16	1.61
[illegible]	1948	28	1.49
[illegible]260	1943	9	1.16
[illegible]1	1931	[illegible]	2.74
9025[illegible]	[illegible]1	17	1.42
[illegible]	[illegible]	[illegible]	1.82
[illegible]	[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]	1.27

I

(2)

Zip Code	Number of Returns	Number of Returns	Percent of Referrals
90[illegible]1	2838	24	0.84
9[illegible]2	2[illegible]1	29	0.99
10003	2719	22	0.80
10006	2[illegible]	23	0.90
90077	[illegible]	17	1.92
[illegible]8	2289	26	1.14
[illegible]	[illegible]	[illegible]	[illegible]
90049	2542	39	[illegible]
[illegible]	[illegible]	17	[illegible]
9[illegible]6	[illegible]	7	1
[illegible]	[illegible]	16	0.61
[illegible]	[illegible]	[illegible]	[illegible]

I-D Study Zip Codes by Area Codes

Zip	CHE	AB	FRC	ATD	Total
90001	3	0	15	1	24
90002	9	7	10	3	29
90003	5	0	17	0	22
90004	11	6	9	3	23
90005	15	0	17	20	52
90006	16	0	16	4	36
90008	19	1	12	0	32
90009	2	0	13	3	18
90043	7	0	7	1	15

Zip	CHE	AB	FRC	ATD	Total
90044	26	6	32	20	104
90047	17	0	6	12	37
90059	2	0	6	1	9
90061	2	0	3	5	10
90062	0	1	23	3	32
90220	0	6	18	3	21
90247	5	0	6	7	30
90249	2	6	4	4	16
90255	1	0	13	4	28

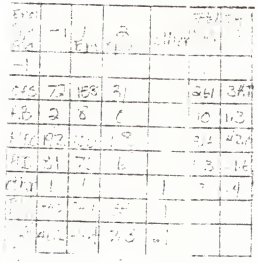
Zip	CHE	AB	FRC	ATD	Total
[illegible]	15	1	13	4	24
[illegible]	32	[illegible]	2	16	53
[illegible]	4	[illegible]	[illegible]	[illegible]	24
[illegible]	[illegible]	[illegible]	1	11	37
[illegible]	[illegible]	[illegible]	14	5	29
[illegible]	6	[illegible]	[illegible]	5	10
[illegible]	2	0	2	1	5
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
Totals	282	10	294	153	779

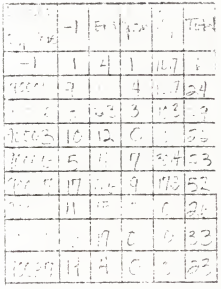
I-E All others repeated Zip codes by Area Code

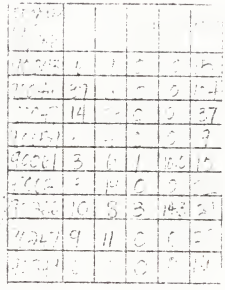
Zip	CHE	AB	FRC	ATD	Total
90005	0	0	3	0	3
90011	0	0	1	3	4
90019	1	0	0	0	1
90036	0	0	1	2	3
90037	0	0	1	0	1
90065	1	0	0	0	1
90066	1	0	0	0	1
90067	0	0	1	0	1
90201	0	0	4	0	4

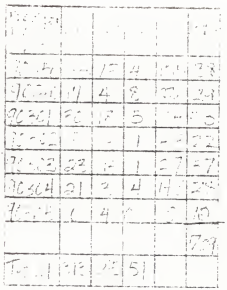
Zip	CHE	AB	FRC	ATD	Total
90245	1	0	1	6	2
90248	1	0	1	0	2
90262	0	0	4	0	4
90266	0	0	2	0	2
90275	0	0	2	1	3
90301	[illegible]	0	0	1	1
90302	[illegible]	0	2	[illegible]	2
90303	[illegible]	[illegible]	[illegible]	0	2
90304	0	0	1	0	1

Zip	CHE	AB	FRC	ATD	Total
90250	[illegible]	0	1	0	1
91209	1	0	0	0	1
90201	2	[illegible]	0	0	2
90202	1	0	0	0	1
Totals	12	0	37	7	44









PREFERENCES

There are two populations of concern in this study, the respondents and the plan personnel. It is important to know as much about each group as possible and one source of information is their stated preferences. These preferences include a basic statement of what the respondents feel is best for them and in return what the plans feel to be best for the potential enrollees and for themselves. Tables IIA through II-I are an attempt to reflect how and by which plans the respondents chose to be contacted. Tables II-J through II-Q represent the plans perspectives.

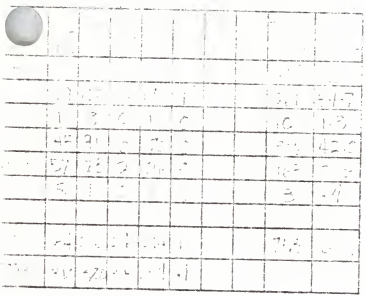
After the respondents indicated that they would like more information about PHPs, they were asked to indicate whether they preferred to be phoned or visited at home. Tables II-A through II-E are a summary of their response to this question. Table II-A is a breakdown of how many persons in each aid category would prefer to be phoned by the plans. It can be seen that a total of 37% of the people wanted to be called, this percentage does not take into account the 28.4% of the contacts which were self initiated by the respondents and which therefore did not require a choice. When these persons are subtracted out, 52% of those people making the decision chose to be phoned. Table II-B shows a finer breakdown of the percent within each aid category who chose to be phoned. The highest group was ATD where 47.9% of the total or 56.9% of the mailer initiated wanted to be phoned. The second alternative, to be visited at home is shown in Tables II-C and II-D. Only 18.9% of the total and 26.4% of the mailer initated wanted to be visited at home. The OAS population was somewaht higher than the other groups with 31.0% of the total and 33.2% of the mailer initiated wanting home visits.

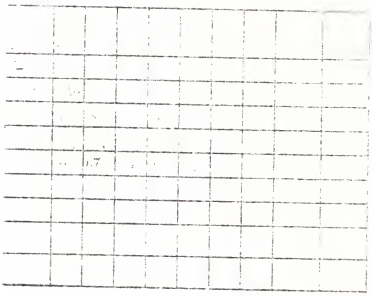
Table II-E clarifies who wanted what by cross referencing phone by home visit. This table indicates that 70 persons did not make any choice at all, 39 persons made errors on their cards, and 214 of the contacts were self-initiated. Of the 424 persons remaining, 280 or 66.0% wanted to be phoned and 142 or 33.5% wanted to be visited.

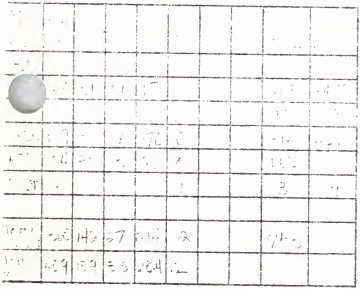
A second decision that had to be made by the respondents was which plan or plans they wanted to contact them. Tables II-F through II-I represent the outcome of this question. The most desirable plan was number four, CMG, which had 40.0% of the total referrals. Plan one, Maxi-Care, was also appealing although its 24.2% of the referrals might not reflect it. However, Maxi-Care was only listed on Lot I cards and the other plans were on Lot I and Lot II. This means that Maxi-Care did not have as much exposure as the other plans. Table II-I shows that when Maxi-Care is compared with the other plans, excluding Lot II responses and missing data, it received 42.2% of the referrals with CMG dropping to 24.0%. CMG was overwhelmingly appealing to the AFDC population as it accounted for 49.7% of the referrals in that category. Some possible explanations for this fact will be explored later.

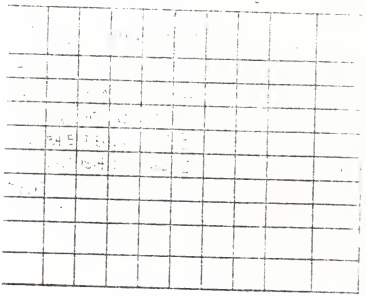
The plans were given four choices as to how they could contact their referrals; home visit, phoning, mailing and waiting for the referrals to walk-in to the plan. On the first contact, phoning had a slight edge over home visits for the total referrals. Tables II-J through II-M give a complete breakdown by plan and method of contact. Plans three and four, Watts and CMG, did not follow the phone trend. Watts chose to make home visits for 94.5% of its referrals while CMG had 41.7% home visits. The second time around all of the plans shifted to home visits with a change from 36.7% to 71.1%. Phoning fell off to a meager 19.9%. Comparing these methods of contact with the respondents initial request, it can be seen that the plans did not always heed the referral's wishes. It can be pointed out that when all persons not making a choice were excluded, 66.0% of the remaining preferred to be phoned and 33.5% wanted to be visited. It is possible that some of the difference was due to confusion by the plans about how the referrals wishes were to be coded on their identification sheets.

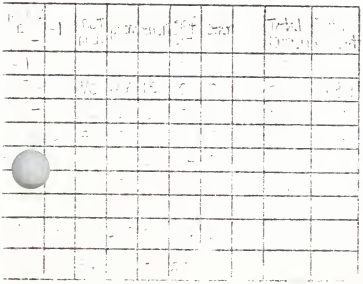
Tables II-N through II-Q explore the relationship between aid code and method of contact. In other words, did the plans treat the categories differently? There is a slight preference to pay home visits to AFDC during both first and last contact, about 7-11% in the first instance and 15% in the second. It is not evident at this point whether this indicates preferential treatment for AFDC; however, Table II-D revealed that of the total AFDC respondents, only 9.5% wanted a home visit. When the self initiated are excluded from this group there is a slight rise to 20.6% wanting home visits, considerably fewer than those actually receiving them.

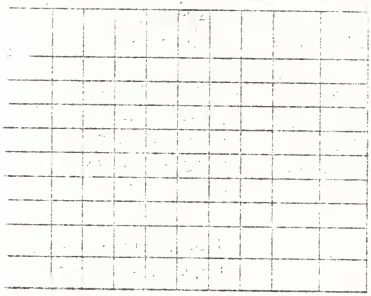


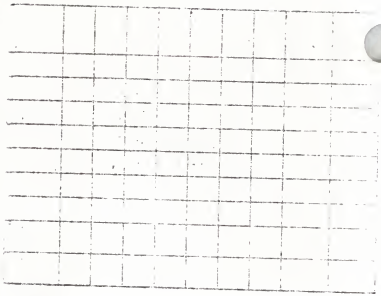


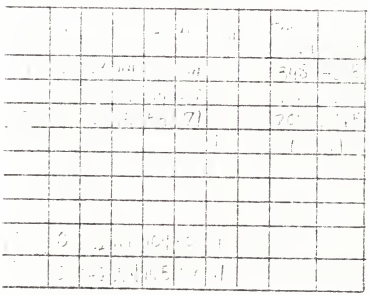


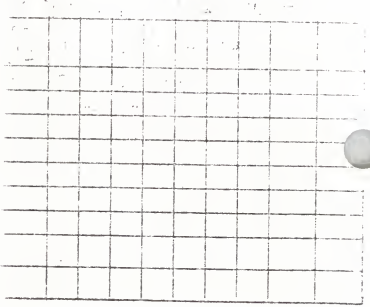


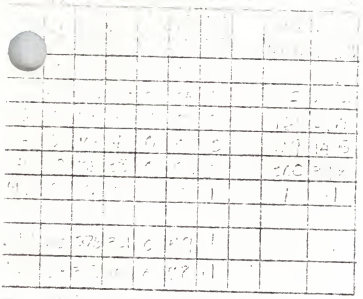


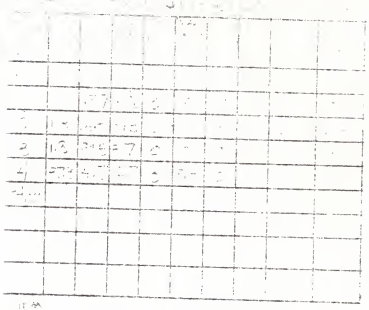


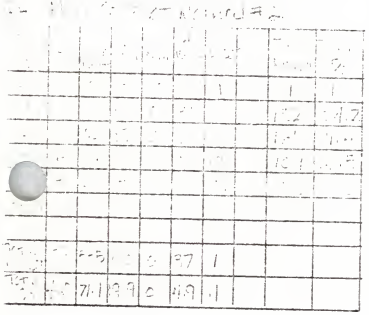


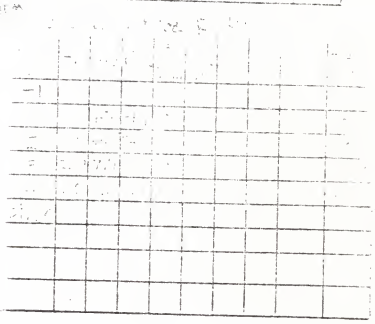


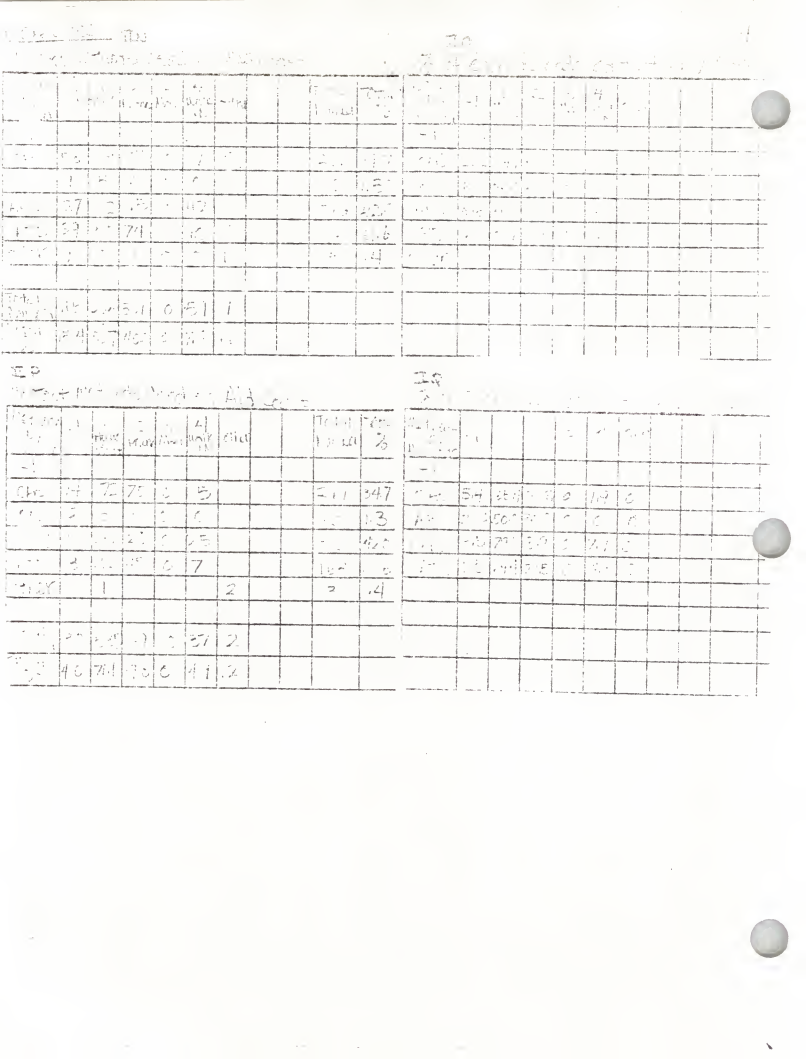












III Process

Since it is impossible to be with each plan and individual as they participated in this experiment, there are ~~many~~ questions which remain unanswered. Many of these questions focus on the "what happened" aspect of the study. What happened when the respondents filled in their response cards? What happened when the plans reported information back to the project? What happened when the plans contacted the individuals? These questions go on and on and one can only infer their answers from the available data. One area that is dependent upon this inferred analysis is that of process, or what actually went on. There is no direct evidence to answer this question but one can gain some insight by studying what went wrong--what errors were made by the plans and by the respondents. An analysis of the errors will serve as a diagnostic and subsequently corrective tool.

Tables III-A through III-N depict some of the coding errors that were made by the plans and by the individuals. Tables IIIA and B represent six types of coding errors that were made by the plans. The decision of what constitutes an error was made by PHRED Membership Studies Staff when they sorted through the cards. Many of the errors are obvious logical impossibilities; a plan might report that a contact resulted in the referral not being home but later on in the card they report that the referral was ~~a verified~~ enrolled. Table III-A lists each plan and six errors: 1) initiation of the contact 2) method of the first contact, 3) results of first contact, 4) number of persons enrolled 5) method of last contact and 6) results of last contact.

It can be seen that the largest source of error was the reporting of how many persons were enrolled. There were 144 errors which accounted for 36.7% of the total ~~in this category~~. The highest plan error rate in ~~this category~~ was CMG's which accounted for 71.4% of their total errors. One contributor to this high error rate was the fact that the field used to represent number enrolled was redifined after the plans received their original coding instructions. This may have led to some confusion about what the field actually represented. The second highest source of errors was the initiation of the contact; was the plan the instigator or the individual? This accounted for 27.7% of the total errors with Watts being responsible for 89% of the errors in this category. The third highest area was method of first contact which accounted for 21.6% of the total.

The overall records of the plans are indicated in Table III-A. The largest error rate was found in Watts with 19.4% of the responses being errors. Maxi-Care had the second highest rate with 12.5%, followed by CMG, 6.2%, and SLACHP, 1.9%.

The overall error rate for all plans and all categories was 8.7%.

Tables III-C through III-N indicate the respondents roll in the process. The cards which were returned by the individuals were checked by PHRED Membership Studues Staff for three types of errors. 1) inconsistent data, 2) incomplete data and 3) too much (or unnecessary) data. These sources of errors were studied first by aid code and then by English and Spanish versions of the card.

Inconsistent data included such errors as choosing to stay on Medi-Cal but requesting more information about PHPs, printing one name and signing another, requesting information but not choosing a plan and selecting phone or visit but not indicating a plan. Table III-C indicates that 31.8% of the total 753 referrals put inconsistent data on their cards. When the 349 missing data cases are subtracted from the total, the percentage jumps to 59% of the remaining referrals. Within the aid categories, OAS had the highest rate with 46.8% of its total making errors, ATD was second with 31.3%. Again these percentages would be higher if one subtracted the missing data. Table III-F breaks down the English/Spanish version cards into those referrals for whom there is data and indicates that 56.2% of the English and 78.2% of the Spanish version cards had errors of inconsistency.

The second source of error was incomplete data, this included the ommitance of address, city, zip code, Medi-Cal number, signature or date. Table III-G shows that the rates were somewhat lower for this type of error with 26.8% of the total and 50% of the available referrals making mistakes. Once again OAS had the highest error rate with 45.6% of the total persons making errors. On the English/ Spanish breakdown in Table III-J it can be seen that 48.4% of the English and 60% of the Spanish version cards contained errors.

The final category of errors was too much data, this included writing a message on the card, putting more than one name on a card, and more than one Medi-Cal number per card. This was the lowest source of errors with only 7.7% of the total and 14.4% of the data available referrals having mistakes. OAS was again the leader with 11.9 of the total having errors. The error rates for English and Spanish were 13.7 and 17.2 respectively.

IIA

Corr.	Initiate corr.		Method #1 corr.		Results #1 corr		Number Enrolled Corr.		Method #2 corr.		Results #2 corr.		Plan Totals		Plan Rej	Totals cents
	no err.	err.	no err.	err.	no err.	err.	no err.	err.	no err.	err.	no err.	err.	no err.	err.	no error	error
1 Maxi Care	179	3	158	24	158	24	136	12	24	2	22	2	182	18	182	18
2 Stachp	161	0	148	16	148	1	141	4	21	3	20	1	169	13	169	13
3 Watts	12	97	82	21	82	1	107	2	17	0	16	1	123	27	123	27
4 CMG	290	9	250	11	244	6	244	50	25	1	24	0	294	12	294	12
TOTAL Number	642	109	636	72	632	27	628	168	87	6	82	4	768	78		
% NE TC	85.5	14.5	89.7	10.3	96.1	3.9	78.9	21.1	93.8	6.2	95.3	.7	91.3	8.7		
% % total Errors		27.7		20.5		7.4		26.7		6.1		.5				

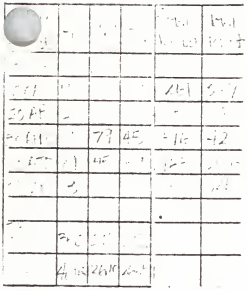
IIB

% of Coding Errors Made in Plan

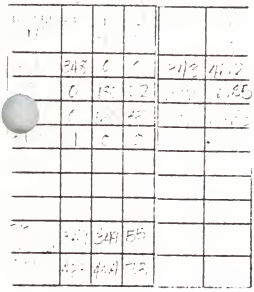
Plan	Initiate corr.	Method #1 corr.	Results #1 corr.	Number Enrolled Corr.	Method #2 corr.	Results #2 corr.				
1	1.7	17.7	17.7	45.5	11.7	5				
2	0	5.4	1.2	0	10.5				15	10.9
3		5.4		1.5	5	5			1.7	
4		7.2			1.9					

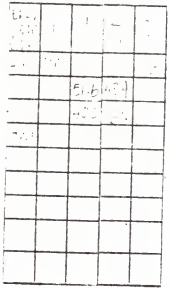
	-1				
				261	24.7
	2	5	3	10	1.3
	3	1		3	.4

II - Incomplete Data



III I Incomplete Data in English/Spanish Cards





III K

	-1	1 Error	2 Errors	Total Number	Total %
-1	0	0	0		
[illegible]	72	158	31	261	34.7
[illegible]	2	8	0	10	1.2
[illegible]	192	113	11	316	21.6
[illegible]	81	66	16	163	21.6
[illegible]	2	1		2	.21
[illegible]	349	[illegible]	[illegible]		
[illegible]	463	413	77		

III L

Too Much Error	-1	1 Error	[illegible]	Total %
-1				
[illegible]	276	665	119	100
[illegible]	20.	80.	0	100
[illegible]	108	358	25	100
[illegible]	49.7	45.5	7.8	100

III M Too Much Error

	-1	[illegible]	[illegible]	Total Number	Total %
-1	24	0	0	24	4.62
[illegible]	0	301	45	216	41.6
[illegible]	0	48	10	58	7.7
	1	0	0	1	.1
[illegible]	349	349	55		
[illegible]	463	463	74		

III N

	-1	[illegible] Error	[illegible] Errors	Total %
-1	100			100
[illegible]		86.3	13.7	100
[illegible]		81.8	17.2	100
[illegible]				

IV TIME FRAMES

One important aspect of this project is time and its productive use. To investigate this issue, three new variables were generated using the available data. These new variables are:1) the amount of time between the state's referral of the individual and the plan's first contact, 2) the time between the referral and the last contact (this is the total amount of time), and 3) the amount of time between the first and last contacts. These variables were given the names Interval 1, Interval 2, and Interval 3 respectively. Table IV-A represents the means of each of these variables for each plan. It can be seen that two means have been calculated for each interval, one with "0" values and one without; the two resultant values are quite different in some instances. There are two factors which led to this situation. First, many of the contacts were self referrals by the eligibles so that their referral date was actually the date of their first contact. This would affect Interval 1 and Interval 2 for plans which had a large number of people who were self initiated. Plans 1 and 4 were in this category and it can be seen from Table IV-A that their means did vary substantially. For the group of people which actually did require a followup, the mean was higher than for the total group of referrals. The second factor is that another large group of people received their first and last contacts on the same day, therefore the interval in time was zero. The effects of this fact would be seen in Interval 3, all of the plans were involved in this practice to some extent. The biggest gap was in plan 3 which went from .64 days to 13.25 days between contacts.

Table IV-B breaks the data out further for Interval 3 and the situation becomes clearer. The number of "0" day encounters are listed in column 5, the number of non-zero days are listed in column 13. The plans began with a total of 753 referrals, of these 144 involved missing data, 3 had errors and 418 had "0" intervals. Of the original 753, 187 or 24.8% actually had non-zero values. This means that 55.5% of the total number of referrals had both contacts on the same day. The median and mode days were also calculated in Table IV-B, these values vary according to the inclusion of the "0" day intervals.

Another area of interest in time centers upon the number of days between the states referral of the plan to an individual and the number of enrollments. Tables IV-C and D illustrate the relationship between time and enrollment for the first and last contacts respectively. It can be seen from IV-C that the highest rate of enrollments per encounters ocurred when the first contact was made within 4 days of referral (the zero days are those persons who were self referred). The rates fall rather fast after 4 days have passed. The same effect was seen in Table IV-D which shows the relationship between referral and last contact and results of the last contact. There seems to be some resurgence in enrollment in the 25-29 days interval.

Numb[illegible] of days between first and l[illegible] contacts by plan

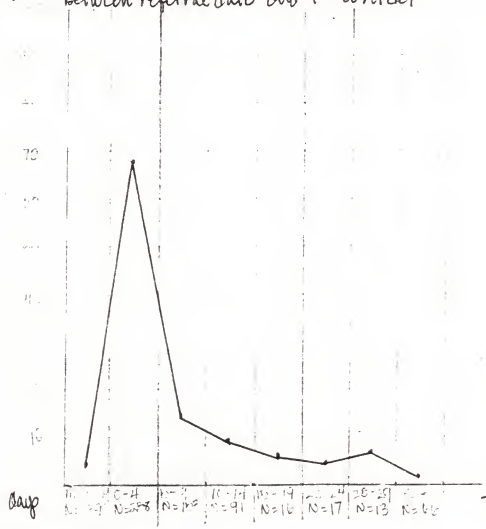
B

PLAN	TOTAL REFERRALS	MISSING DATE	ERROR (OTHER MINUS VALUES)	"C" DAYS BETWEEN REFERRAL	MEAN WITH 0's INCLUDED (DAYS)	MEDIAN WITHOUT 0's (DAYS)	MEDIAN WITH 0's INCLUDED DAYS	MEDIAN WITHOUT 0's (DAYS)	MODE WITH 0's (DAY)	MODE WITHOUT 0's (DAYS)	RANGE (days)	Total Number Excluding Missing "C" Values
1 MAVI CARE	151	0	2	119	2.89	8.48	0	8	0	1	0-47	90
2 SUNCHP	161	2	0	103	1.71	4.86	0	5	0	1	0-19	56
3 WHTE	[illegible]	26	1	79	.64	13.25	0	*	0	*	0-38	4
4 PNG	300	116	0	117	.76	2.07	0	1	0	2	0-6	67
[illegible]	1											
Total	613	144	3	418								217

* not a large enough N (4) for calculation

MAXI-CODE	6.72		3.4K
SLACKID	4[illegible]	4[illegible]	[illegible]
WATTS	8.13	[illegible]	[illegible]
CMG	2.58	[illegible]	[illegible]

Results by 1st contact
% enrolled (of referrals) by number of days between referral date and 1st contact



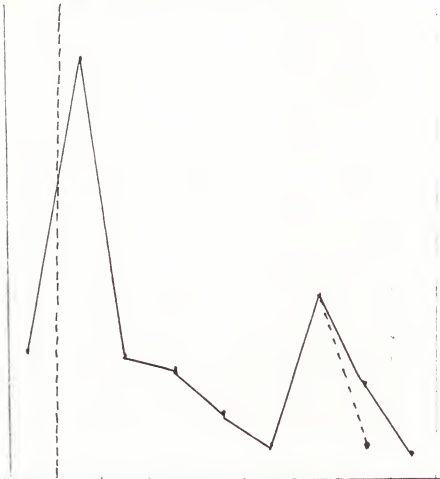
Total N = 753

range = 0 - 144 days

D

Results 2 by last contact

% enrolled (of referrals) by number of days between referral date and last contact



Total N=753

range = 0 - 144 days

V OUTCOME

There are many different outcomes that need to be considered in this section; each asks a basic question, how did this element affect the number of persons enrolled? The first variable, method of initiation, is addressed in Tables V-A through D. There were three methods of inititation which could occur, 1) plan follow-up, 2) respondent follow-up as a result of the mailer and 3) respondent initiated without prior contact with the mailer. It can be seen from Table V-B that of those contacts resulting in a verified enrollee on the first try, 61.2% were plan initiated, 19.6% were respondent initiated as a result of the mailer and 18.7% were not mailer related. In all, there were 134 reported cases in which one or more persons were enrolled by the plans on the first contact. By the last contact, this number had jumped to 174 instances of enrollment. The percentages for the last contact are somewhat different than those on the first with plan follow-up dropping slightly to account for 54.5% of the enrollments. Self referred as a result of the mailer also dropped slightly to 15.4% while self referred without the mailer rose to 21.6%.

From the way the plans coded the referral sheets it appears that there were 219 contacts that resulted in verified enrollments on the first contact and 319 on the last contact. In addition, 20 contacts on the first trial and 34 in the last were listed as enrolled in another plan or as having an advanced enrollment. This would seem to imply that 592 total contacts resulted in enrollments. To check this out, the results of the first contact were compared with the results of the last contact. It can be seen from Table V-E that 211 contacts were marked as being verified enrolles on <u>both</u> the first and last trials. There were 45 other contacts in other enrollment categories which were also coded in this manner. Since this is a duplication of counting, these 256 enrollments must be subtracted from the total leaving 336 contacts reportedly resulting in enrollments. These 336 contacts compose 44.6% of the total 753 referrals. Thus from these reported results the plans had a fairly high success rate. This is especially true when taken in light of the fact that for AFDC referrals it was possible to enroll more than one person at a time.

Tables V-G through J demonstrate the relationship between the method of contact and outcome. The plans could contact the referrals in one of

four ways, 1) home visit, 2) telephone, 3) mail and 4) walk-in (by the respondent into the plan. Table V-H indicates that of the 219 reported verified enrollments on the first contact, 111 or 50.7% came about as a result of home visits. This was followed by telephone, 26.5% and walk-in, 22.8%. This figure changed rather dramatically on the last contact where home visits accounted for 277 or 86.8% of the verified enrollments by the plans. It must be remembered that the plans changed their stated method of contact on the last time around. (See Tables II-J through M). The plans went from 40% telephone contacts to 19.9% on the last try.

Tables V-K through M attempt to show another aspect of outcome, the number enrolled for each plan. Table V-K shows the number of referrals that resulted in enrollments for each plan while Table V-L illustrates the actual stated number of persons enrolled. For example, in V-K plan 1 had 181 referrals result in enrollments for a total, from V-L of 252 persons. Plan 4 had the highest number of enrollments with a total of 372 persons on 242 referrals. Plans 2 and 3 did not do as well as they only reported 41 and 29 enrollees respectively. Taking these figures one step farther, it can be seen that plan 1 averaged 1.39 persons per enrollment, plan 2 had 2.05, plan 3 had 1.53 and plan 4 had 1.54. The overall rate was 1.50 enrollees per verified enrollment contact.

Tables V-N through P reflect the relationship between initiation and the actual number of persons enrolled. Table V-N indicates that when missing data and non-enrollments are discarded, 55% of the remaining contacts which did result in enrollments were plan initiated follow-ups. The other 45% was distributed somewhat evenly between missing data (on initiation), self as a result of the mailer and self with no mailer. When the total number of enrollments are examined in Table V-O it can be seen that the plan accounted for 377 or 54.3% of the total enrollments. The rates for the number enrolled per contact were missing data, 1.08; plan follow-up, 1.48; self with mailer, 1.89; self no mailer, 1.66. It appears that self referral with mailer contact was the most efficient in terms of number enrolled per contact.

Another important aspect of enrollment is established in Tables V-Q through S, here the relationship is between outcome and aid code. An inter-

esting factor which would be expected to happen did occur within this outlook. It can be seen from examining the tables that AFDC was by far the most economical of the aid codes as far as the number of enrollments per encounter is concerned. Table V-Q indicates that AFDC accounted for 51.1% of the encounters that ended in enrollments, but it rose 15% to account for 66.7% of the total number of persons enrolled. The rates for the aid codes were OAS, 1.02; AB, 1.00; AFDC, 1.96; and ATD 1.03. Another interesting fact is evident in Table V-Q, the ratio of referrals by contacts resulting in enrollments for the different groups. The rates are the following; OAS, 46.6%; AB, 50%; AFDC, 74.7%; ATD, 60.0%. AFDC not only had the highest number of persons per enrollment but the best percentage of enrollments per contact, that is 74.4% of the AFDC contacts resulted in reported enrollments.

The question that has not been answered in this section is, how accurate is this data? Tables V-T through W attempt to explore this query. In order to get at any discrepancies that might exist in the data between the reported results of the first contacts and the number of persons enrolled, a cross tabulation was done between the two variables. It is theoretically impossible for four of the six result categories to end up in enrollments. That is, if there was no contact, the person could not be enrolled. Table V-T can not look at this problem as accurately as Table V-V because the person may not have been enrolled on the first contact but on the last. The coding sheet did not allow for a direct relationship between which contact resulted in the enrollment, however it would seem that the last contact might be more summative and inclusive. So, going from the assumption that the last contact might be more accurate, it can be seen that 140 cases or 141 individuals were listed as enrolling when it was not warranted by the reported results. For instance, looking at Table V-V it can be seen that under the category of results "will not continue on Medi-Cal", there were 97 instances when one person was marked as enrolling. It would be tempting then to subtract these overlapping encounters from the total but it is possible that this would not be correct either. The column for number enrolled was originally meant to indicate the type of initiation of the contact, it could be that the plans were following the old directions and wrote in "one" meaning that the contact was plan initiated. At any rate, the percentage of errors for this relationship appears to be 18.6% on the last contact.

IA Initiation and Outcome of First Contact

Initiator's Report	-1	1	2	3	other			Total Number	Total %
-1	116	63	2	0				181	24.0
1	1	124	43	41				219	29.1
2	0	100	73	1				179	23.8
3	6	47	5	0				58	7.7
4	0	10	2	0				12	1.6
5	0	2	5	1				8	1.1
6	1	55	15	28				99	13.1
Total Number	118	411	152	71	-1				
Total %	15.7	54.6	20.2	9.4	.1				

IB Percent of Each Result by Initiator

Initiator's Report	-1	1	2	3	other				Total %
-1	64.1	34.8	1.1	0	0				100
1	55.7	45.6	18.3	17.4	0				100
2	0	55.9	40.8	.5	0				100
3	10.3	81.0	8.6	0	0				100
4	0	83.3	16.6	0	0				100
5	0	25.0	62.5	12.5	0				100
6	1.0	55.6	15.2	28.3	0				100
Total Number	118	411	152	71	1				
Total %	15.7	54.6	20.2	9.4	.1				

IC Initiation and Outcome of Last Contact

Initiator's Report	-1	1	2	3	other			Total Number	Total %
-1	15	1	26	0	0			42	4.3
1	27	174	49	69	0			319	42.3
2	62	15	71	3	0			206	23.5
3	8	24	3	0	0			67	8.9
4	14	17	0	0	0			31	4.1
5	0	1	2	0	0			3	.4
6	2	6	1	0	0			8	1.1
Total Number	118	411	152	71	1				
Total %	15.7	54.6	20.2	9.4	.1				

ID Percent of Each Result by Initiator

Initiator's Report	-1	1	2	3	other				Total %
-1	15.0	3.1	81.2	0	0				100
1	8.5	54.5	15.4	21.6	0				100
2	31.4	62.3	24.1	.7	0				100
3	12.0	83.6	4.1	0	0				100
4	45.2	54.8	0	0	0				100
5	0	66.7	33.3	0	0				100
6	25.0	75.0	0	0	0				100

I Outcome

IG Method 1 and Outcome of First Contact

Method 1	-1	1	2	3	4	other		Total Number	Total %
1	116	12	53	0	6	-		181	24.6
Verbal Warning	0	111	105	0	3	-		219	29.1
Written Warning	0	42	82	0	1	0		179	23.8
Verbal Warning & Written Warning	0	27	24	0	1	0		52	6.9
Arrest	0	5	7	0	0	0		12	1.6
Search	0	2	6	0	0	0		8	1.1
Other	0	21	71	0	7	0		99	14.1
Total Number	116	420	348	0	18	0	+1	+3	.4
Total %	15.4	36.7	46.0	0	2.8	.1			

IH Percent of each Result by Method

Method	-1	1	2	3	4	other			
1	64.1	6.6	29.3	0	3.3	-			
Verbal Warning	0	50.7	47.9	0	1.4	-			
Written Warning	0	23.5	45.8	0	.6	0			
Verbal Warning & Written Warning	0	51.9	46.2	0	1.9	0			
Arrest	0	41.7	58.3	0	0	0			
Search	0	25.0	75.0	0	0	0			
Other	0	21.2	71.7	0	7.1	0			

II Method 2 and Outcome of Last Contact

Method 2	-1	1	2	3	4	other		Total Number	Total %
1	39	3	6	0	6	0		54	4.3
Verbal Warning	1	277	5	0	2	0		219	41.4
Written Warning	0	154	122	0	1	0		277	22.5
Verbal Warning & Written Warning	0	47	0	0	0	0		47	3.9
Arrest	0	50	1	0	0	0		51	4.1
Search	0	4	0	0	0	0		4	.35
Other	0	12	16	0	0	0		0	1.1
Total Number	30	525	150	0	9	0	+1		.35
Total %	4.0	71.0	20.0	0	4.9	.1			

IJ Percent of each Result by Method

Method 2	-1	1	2	3	4	other			
1	72.2	5.6	11.1	0	11.1	0			
Verbal Warning	.5	79.8	1.4	0	.6	0			
Written Warning	0	55.6	44.0	0	.4	0			
Verbal Warning & Written Warning	0	89.4	0	0	0	0			
Arrest	0	98.0	2.0	0	0	0			
Search	0	100	0	0	0	0			
Other	0	42.9	57.1	0	0	0			

Appendix

IE Results from first contact by results from last contact

Result from first contact	Result from last contact									
	-1	1	2	3	4	5	6	7	Total	Column %
-1	7		3	0	2	4	0	2	18	4.2
1	27	511		15	1	3	12	1	570	23.5
2	94	2	28	F	6	2	24	2	158	38.8
3	31	0	6	34	6	2	2	1	82	7.1
4	26	2	0	0	9	6	6	3	52	4.1
5	1	2	2	1	2	1	0	3	12	1.4
6	1	0	0	0	0	0	7	5	13	1.1
Total	181	39	80	52	12	8	79	437		
Column %	41.4	8.2	18.3	11.9	2.6	1.8	18.2			5.2

Percentages Results from first contact by results from last contact

Result from first contact	-1	1	2	3	4	5	6	7	Total
-1	38.9	2.8	16.7	5.6	11.1	22.2	0.0	11.1	100.0
1	4.7	89.7	0.4	2.6	0.2	0.5	2.1	0.2	100.0
2	59.5	1.3	17.7	[illegible]	3.8	1.3	15.2	1.3	100.0
3	37.8	0.0	7.3	41.5	7.3	2.4	2.4	1.2	100.0
4	50.0	3.8	0.0	1.9	17.3	11.5	11.5	3.8	100.0
5	8.3	16.7	16.7	8.3	16.7	8.3	0.0	25.0	100.0
6	7.7	0.0	0.0	0.0	0.0	0.0	53.8	38.5	100.0
Total	41.4	8.9	18.3	11.9	2.7	1.8	18.1	7.1	100.0

IK Numbers of Enrollments by Plan

	-1 NO ENROLL	0	1	2	3	4	5	6	TOTAL NUMBER ENROLLMENTS
-1	0	0	0	0	0	0	0	0	
1	0	1	144	14	2	2	4	1	167
2	2	2	10	4	3	1	0	1	26
3	34	37	14	3	1	1	1	0	19
4	27	31	12	35	22	12	2	15	242
									462
TOTAL	63	235	180	56	41	12	7	2	
		298	480	224	123	48	35	12	

IL Total

	-1 NO ENROLL	0	1	2	3	4	5	6	TOTAL NUMBER ENROLLMENTS
-1									
1			1	144	14	2	2	4	167
2	2			10	4	3	1	0	26
3	34	37		14	3	1	1	0	19
4	27	31		12	35	22	12	2	242
									462
TOTAL	63	235	180	56	41	12	7	2	
		298	480	224	123	48	35	12	

IM

	-1 NO ENROLL	0	1	2	3	4	5	6	TOTAL NUMBER ENROLLMENTS
-1	0	0							
1	0	1	144	14	2	2	4	1	167
2	2	2	10	4	3	1	0	1	26
3	34	37	14	3	1	1	1	0	19
4	27	31	12	35	22	12	2	15	242
									462
TOTAL	63	235	180	56	41	12	7	2	
		298	480	224	123	48	35	12	

| | | |

CUTHBERT

IR

HOUSE MASTER'S END OF TERM REPORT

	1										
	21	24	17	53	46	12	7	6			
	4		25	1	1	0	0				
	53	24	17	53	41	12	7	6			
	17.0	21.6	45.2	7.4	5.5	1.6	.9	.8			

IIR

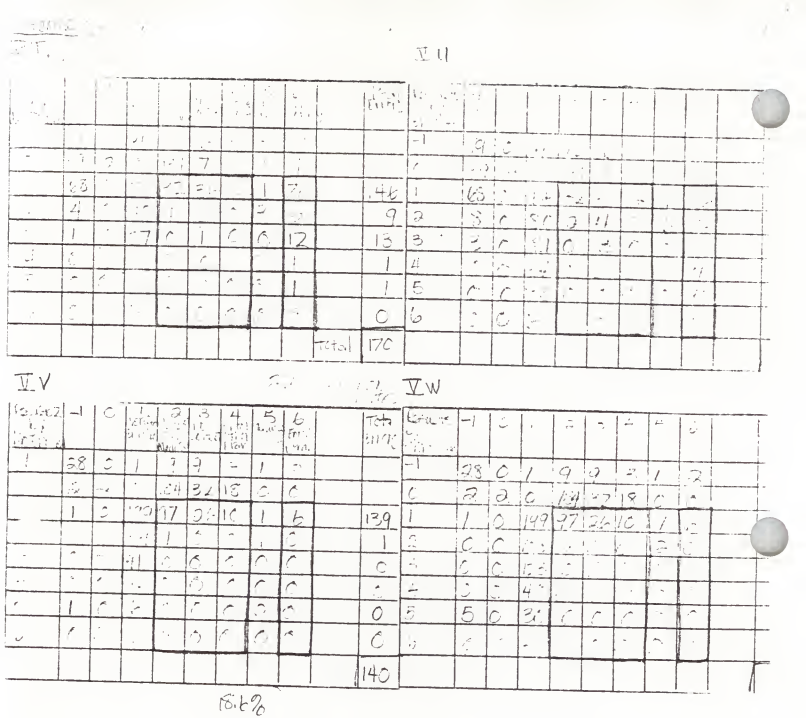
	-1	0	1	2	3	4	5				
	21	59	113	106	120	61	25	26	66.7		
	4	42	25	2	2	3	0	0	4.4		
									2		
	53	42	13	2	2	3	0	0	4.4		

IIS

	16.3	43.1	34.1	4.3	0	0	0	0	14.4	100	
	10.0	45.0	32.5	0	0	0	0	0	12.5	100	
	1.6	18.7	27.3	16.3	12.7	2.8	2.2	1.9	14.7	100	
	2.5	38.0	28.3	6.6	1.6	0	0	0	59.5	100	

HAS = 46.6
HP = 80.0
HC = 74.1
HTD = 60.0

1.02
1.00
1.96
1.83



SANTA CLARA MAILING

Dual Choice Information for Medi-Cal Eligibles

21 June 1978

This is a report of the PHRED Project. PHRED--Prepaid Health Research, Evaluation & Demonstration--is supported by an HEW grant (No.96-P-90299/9-01) to the California Department of Health.

Summary

Following is a summary of the results of a mailing of Medi-Cal Program information offering enrollment to eligible beneficiaries living in portions of the service areas of the two prepaid health plan contractors in Santa Clara County.

1.	No. of information packets mailed...	5,900
2.	No. delivered to addressee...	5,707
3.	No. of cards returned...	819
	a) ...as percent of packets delivered...	14%
	b) percentage of cards requesting information about one or both health plans	14%
4.	No. of persons enrolled...	33
5.	Enrollments as a percent of number of individuals requesting information...	22%
6.	Enrollments as a percent of total responses...	.04%
7.	Cost* of mailing...	$2,533
8.	Cost* per enrollment...	$ 77

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* Includes printing and mailing charges.

To pre-test some of the methods proposed for the Membership Studies component and to assist the Alternative Health Systems Branch (AHSB) in a marketing by mail effort requested by the Deputy Director, PHRED staff provided technical assistance to the AHSB in development of a marketing information package mailed to samples of Los Angeles and Santa Clara County Medi-Cal eligibles. Following is a report of the mailing for the two plans in Santa Clara County: Health Alliance of Northern California, Inc. (HANC) and Family Health Foundation of Alviso, Inc. (Alviso). The results of the Los Angeles mailing will be reported separately.

I. Background

The mailing consisted of a brochure, return postcard, and cover letter which was signed by the Deputy Director. All were in both English and Spanish. The cover letter included a DOH toll-free number to call for more information or to ask questions. The brochure explained the difference between a Medi-Cal card and enrollment in a PHP, gave a brief description of the plan (or in one area both plans) and instructions on how to indicate a choice on the postcard to: (1) continue to receive a Medi-Cal card; (2) get more information on a plan; (3) enroll in a plan. The postcard gave a choice of contact by telephone or home visit for those requesting more information. The brochure also requested that the beneficiaries return the postcard with their signature, address and telephone number, regardless of their decision. (The materials are attached as Appendix 1.)

Three separate areas were chosen for the mailing. Area 1 serves both plans and has approximately 2,400 Medi-Cal eligibles. Area 2 (Alviso) and Area 3 (HANC) were chosen because each plan had recently opened new facilities nearby. There are about 4,500 and 6,700 eligibles, respectively, in those areas.

II. Results

Packets were mailed to approximately 5,900 households.* Area 1 received about 900; Area 2, about 2,000; and Area 3, about 3,000. Of the total mailed, more than 800 postcards have been returned to date, a return ratio of nearly 14 percent.

Table 1: Cards Returned by Type of Choice

Continue Medi-Cal card	683
Find out about PHP	106#
Enroll in a Plan	18
Blank	12
Total	819

#Includes 8 who marked both "find out" and "enroll."

*Three percent of the total packets mailed, 193, were returned unopened, indicating that those beneficiaries had moved and left no forwarding address.

Of those asking for more information about one or both health plans, 35 households requested telephone contact; 32, a home visit; 14 indicated no preference; and the remainder marked "either/or". These responses are broken down by plan in Table 2.

Table 2: Requests for Information by Type of Contact

	Area 1		Area 2	
	Alviso	HANC	Alviso	
No preference given	2	9	3	14
Call	-0-	5	3	27
See	2	16	5	9
Either/or	-0-	-0-	2	9

Twenty-three percent of the respondents requesting more information were Spanish-surnamed. Of those, six (or 25 percent) returned the Spanish card. One of those six returned both the English and the Spanish. None of these enrolled. One card was not received until April 10. The somewhat low percentage of the Spanish card return might indicate either that most Spanish-surnamed persons contacted feel comfortable in the English language or that most think it is better to respond to an "official" State mailing in English.

Overall, HANC received the majority, 80 percent, of the referrals for information or possible enrollment. Of these total requests, 54 percent came from the HANC-only Area 3 and 26 percent from Area 1, which received information about both plans. Within Area 1, 89 percent of the responses favored HANC. This disproportion may reflect several factors: HANC had conducted an extensive advertising campaign just before the State mailing and people may have been motivated to respond when given the opportunity. And in Area 1, many beneficiaries had already been offered enrollment in Alviso through that repeated plan's door-to-door solicitation. Presumably, those attracted to Alviso may have already been enrolled. HANC, which has not employed door-to-door solicitation as a marketing method for several years, was offered essentially for the first time to most residents of Area 1 through the mailing. Finally, the population of Medi-Cal beneficiaries in the two areas receiving information about HANC was larger than the population receiving information about Alviso.

A small percentage, 11 percent, of the respondents requesting more information on either or both health plans enrolled. A much higher proportion, 67 percent, of those choosing "enrollment" on the cards actually enrolled. In a telephone survey of a sample of those who decided to stay on regular Medi-Cal after exposure, the most common reason given was the desire to continue seeing current physicians. Although this limitation was pointed out in the mailed information, evidently the point was not made until the respondents heard it from a plan representative. (See IV below for a report on the telephone survey and enrollment verifications.)

The breakdown of respondents into welfare aid classifications is skewed with a larger number of SSI/SSP recipients (58 percent) (the aged, blind and disabled "adult aid" categories) than is represented in the usual Medi-Cal population in which AFDC (Aid to Families with Dependent Children) constitutes the bulk of the recipients (67 percent). Here SSI/SSP and AFDC split approximately 50-50. This fact is also reflected in the relatively low number of persons per responding household--152 people/124 households, or 1.2 per household. The usual Medi-Cal estimate of family-case size is more than 3 people per household on aid. Not all cards requesting information included aid code information but there is no reason to think that there was a bias toward giving this data for SSI/SSP. The greater than proportionate response from SSI/SSP recipients, then, could mean that more were reached by (that is, received, and read) the information and/or that more were motivated to respond. Table 3 below gives the break-down by aid code category for the 33 enrollments which resulted from the 124 requests for information.

Table 3: Enrollments by Aid Category

AFDC	16
Aged	8
Disabled	7
No Aid Code	2

III. Telephone Survey of Mailing Respondents

A sample consisting of 35 beneficiaries who responded to the mailing with various choices was interviewed by telephone to assess general understanding of the purpose and intent of the mailing. There were six questions which allowed the beneficiary to respond favorably or unfavorably. Responses* are summarized below by questions:

1. *What did you think you had to do, if anything, when you received the information in the mail?*

   - Two people thought they had to enroll.
   - Two people thought they had to send the card back to continue their welfare aid.
   - Seven understood they didn't have to do anything.
   - Seven understood they could get more information.

2. *Did the information help you?*

   - Twenty-nine people said they found the information helpful.
   - Two felt it gave them information about prepaid health plans.
   - Four people said the information didn't help them.

*Some responses do not total the number of respondents because not everyone answered all questions and some gave more than one answer.

3. *Have you or anyone in your family ever joined a prepaid health plan?*

   - Thirty-one said no member of their families had ever joined a prepaid health plan.
   - Four persons said they had joined a plan before. In each case, the plan they named was Kaiser.

4. *Why did you decide to stay on Medi-Cal? (Asked when appropriate)*

   - Fourteen decided to stay with their present providers.
   - Eight said they were able to find a doctor who takes Medi-Cal when they needed care.
   - Only two said the plan "didn't sound good" after they had been given more information by the plan.
   - One said she was not happy with her present provider but she wanted to stay with him because he and her hearing doctor had "some kind of group deal" and "good doctors are hard to find that will take Medi-Cal cards."

5. *Why did you decide not to join a prepaid health plan? (Asked when appropriate)*

   - Fourteen people said they could not continue to see their doctors.
   - Four said the facilities were located too far away from their homes.
   - Four said transportation was a problem.
   - One person didn't like the presentation by the plan.

6. *You asked for information about enrollment in a prepaid health plan. What contact did you have with the plan? (Asked when appropriate)*

   - Fourteen were sent information in the mail.
   - Three received phone calls from the plan.
   - Two people called the plan.
   - Five people had had no contact at all.
   - Three were still waiting to hear from the plan. (They were given the plan's phone numbers by the interviewer.)
   - Two couldn't remember the name of the plan about which they had requested more information. (The interviewer reminded them of their choice and gave them the plan's telephone number.)
   - One person was not eligible.

In addition to the telephone interviews of those who did not enroll, calls were made to verify enrollments resulting from the mailing. The form used has thirteen questions directed toward the beneficiary's understanding of enrollment in a prepaid health plan.

The key questions are tabulated below for the small sample interviewed:

1. *First, I want to be sure you understand that you have enrolled yourself (and _____, if anyone else in the family) in a prepaid health plan?*

   All respondents understood they had joined a plan. They all said they knew what they were doing when they filled out the form.

2. *Has anyone from the health plan called or come to see you to ask if you had any questions about services?*

   - Eight people said yes.
   - Seven had had phone verification.
   - Only one had no contact due, evidently, to her moving almost immediately after she enrolled.

3. *What did you think you had to do when you got the mailing?*

   - Five knew it was to get more information.
   - Only one said "do nothing."

4. *Did the mailing help you?*

   - Eight people said it gave them information.
   - One person felt it was very helpful.

5. *Why did you decide to enroll?*

   - Four people couldn't find a doctor who would take their Medi-Cal cards.
   - Four others said the plan "sounded good."
   - One said the plan system "sounded easier."
   - One person reported having to wait too long in the doctor's office.
   - One said, "You can't find good services from doctors who will take Medi-Cal people."

6. *Has anyone in your family ever joined a prepaid health plan before?*

   Responses totalled one yes and seven no.

7. *What is your current address?*

   All were matches except for the one who had moved out of the service area.

8. *Have you received a plan booklet explaining the services available?*

   Again, the only no was the one person who had moved.

9. *Do you understand that joining _____ was completely voluntary and that you don't have to enroll to keep your aid or food stamps?*

   Everyone, seven, answered yes except one person. (This response was referred to the contract manager.)

10. *Do you understand that you signed up for a period of one year, but that you can get out for any reason during the 3-day trial period?*

    All eight people said they understood.

11. *Did anyone check to see if you are under a doctor's care?*

    - Six responded no.
    - Two said yes. (These responses were referred to the contract manager.)

12. *Do you understand that you cannot go back to your current doctor unless he or she is on the plan's list?*

    Everyone (eight) said yes.

SANTA CLARA MAILING

Dual Choice Information for Medi-Cal Eligibles

21 June 1978

This is a report of the PHRED Project. PHRED--Prepaid Health Research, Evaluation & Demonstration--is supported by an HEW grant (No.96-P-90299/9-01) to the California Department of Health.

Summary

Following is a summary of the results of a mailing of Medi-Cal Program information offering enrollment to eligible beneficiaries living in portions of the service areas of the two prepaid health plan contractors in Santa Clara County.

1.	No. of information packets mailed...	5,900
2.	No. delivered to addressee...	5,707
3.	No. of cards returned...	819
	a) ...as percent of packets delivered...	14%
	b) percentage of cards requesting information about one or both health plans	14%
4.	No. of persons enrolled...	33
5.	Enrollments as a percent of number of individuals requesting information...	22%
6.	Enrollments as a percent of total responses...	.04%
7.	Cost* of mailing...	$2,533
8.	Cost* per enrollment...	$ 77

* Includes printing and mailing charges.

To pre-test some of the methods proposed for the Membership Studies component and to assist the Alternative Health Systems Branch (AHSB) in a marketing by mail effort requested by the Deputy Director, PHRED staff provided technical assistance to the AHSB in development of a marketing information package mailed to samples of Los Angeles and Santa Clara County Medi-Cal eligibles. Following is a report of the mailing for the two plans in Santa Clara County: Health Alliance of Northern California, Inc. (HANC) and Family Health Foundation of Alviso, Inc. (Alviso). The results of the Los Angeles mailing will be reported separately.

I. Background

The mailing consisted of a brochure, return postcard, and cover letter which was signed by the Deputy Director. All were in both English and Spanish. The cover letter included a DOH toll-free number to call for more information or to ask questions. The brochure explained the difference between a Medi-Cal card and enrollment in a PHP, gave a brief description of the plan (or in one area both plans) and instructions on how to indicate a choice on the postcard to: (1) continue to receive a Medi-Cal card; (2) get more information on a plan; (3) enroll in a plan. The postcard gave a choice of contact by telephone or home visit for those requesting more information. The brochure also requested that the beneficiaries return the postcard with their signature, address and telephone number, regardless of their decision. (The materials are attached as Appendix 1.)

Three separate areas were chosen for the mailing. Area 1 serves both plans and has approximately 2,400 Medi-Cal eligibles. Area 2 (Alviso) and Area 3 (HANC) were chosen because each plan had recently opened new facilities nearby. There are about 4,500 and 6,700 eligibles, respectively, in those areas.

II. Results

Packets were mailed to approximately 5,900 households.* Area 1 received about 900; Area 2, about 2,000; and Area 3, about 3,000. Of the total mailed, more than 800 postcards have been returned to date, a return ratio of nearly 14 percent.

Table 1: Cards Returned by Type of Choice

Continue Medi-Cal card	663
Find out about PHP	106# 13%
Enroll in a Plan	18 ≈ 1.5%
Blank	12
Total	819

#Includes 8 who marked both "find out" and "enroll."

*Three percent of the total packets mailed, 193, were returned unopened, indicating that those beneficiaries had moved and left no forwarding address.

Of those asking for more information about one or both health plans, 35 households requested telephone contact; 32, a home visit; 14 indicated no preference; and the remainder marked "either/or". These responses are broken down by plan in Table 2.

Table 2: Requests for Information by Type of Contact

	Area 1		Area 2	
	Alviso	HANC	Alviso	
No preference given	2	9	3	14
Call	-0-	5	3	27
See	2	16	5	9
Either/or	-0-	-0-	2	9

Twenty-three percent of the respondents requesting more information were Spanish-surnamed. Of those, six (or 25 percent) returned the Spanish card. One of those six returned both the English and the Spanish. None of these enrolled. One card was not received until April 10. The somewhat low percentage of the Spanish card return might indicate either that most Spanish-surnamed persons contacted feel comfortable in the English language or that most think it is better to respond to an "official" State mailing in English.

Overall, HANC received the majority, 80 percent, of the referrals for information or possible enrollment. Of these total requests, 54 percent came from the HANC-only Area 3 and 26 percent from Area 1, which received information about both plans. Within Area 1, 89 percent of the responses favored HANC. This disproportion may reflect several factors: HANC had conducted an extensive advertising campaign just before the State mailing and people may have been motivated to respond when given the opportunity. And in Area 1, many beneficiaries had already been offered enrollment in Alviso through that repeated plan's door-to-door solicitation. Presumably, those attracted to Alviso may have already been enrolled. HANC, which has not employed door-to-door solicitation as a marketing method for several years, was offered essentially for the first time to most residents of Area 1 through the mailing. Finally, the population of Medi-Cal beneficiaries in the two areas receiving information about HANC was larger than the population receiving information about Alviso.

A small percentage, 11 percent, of the respondents requesting more information on either or both health plans enrolled. A much higher proportion, 67 percent, of those choosing "enrollment" on the cards actually enrolled. In a telephone survey of a sample of those who decided to stay on regular Medi-Cal after exposure, the most common reason given was the desire to continue seeing current physicians. Although this limitation was pointed out in the mailed information, evidently the point was not made until the respondents heard it from a plan representative. (See IV below for a report on the telephone survey and enrollment verifications.)

The breakdown of respondents into welfare aid classifications is skewed with a larger number of SSI/SSP recipients (58 percent) (the aged, blind and disabled "adult aid" categories) than is represented in the usual Medi-Cal population in which AFDC (Aid to Families with Dependent Children) constitutes the bulk of the recipients (67 percent). Here SSI/SSP and AFDC split approximately 50-50. This fact is also reflected in the relatively low number of persons per responding household--152 people/124 households, or 1.2 per household. The usual Medi-Cal estimate of family-case size is more than 3 people per household on aid. Not all cards requesting information included aid code information but there is no reason to think that there was a bias toward giving this data for SSI/SSP. The greater than proportionate response from SSI/SSP recipients, then, could mean that more were reached by (that is, received, and read) the information and/or that more were motivated to respond. Table 3 below gives the break-down by aid code category for the 33 enrollments which resulted from the 124 requests for information.

Table 3: Enrollments by Aid Category

AFDC	16
Aged	9
Disabled	7
No Aid Code	2

III. Telephone Survey of Mailing Respondents

A sample consisting of 35 beneficiaries who responded to the mailing with various choices was interviewed by telephone to assess general understanding of the purpose and intent of the mailing. There were six questions which allowed the beneficiary to respond favorably or unfavorably. Responses[1] are summarized below by questions:

1. *What did you think you had to do, if anything, when you received the information in the mail?*

   - Two people thought they had to enroll.
   - Two people thought they had to send the card back to continue their welfare aid.
   - Seven understood they didn't have to do anything.
   - Seven understood they could get more information.

2. *Did the information help you?*

   - Twenty-nine people said they found the information helpful.
   - Two felt it gave them information about prepaid health plans.
   - Four people said the information didn't help them.

[1] The responses do not total the number of respondents because not everyone answered all questions and some gave more than one answer.

3. *Have you or anyone in your family ever joined a prepaid health plan?*

- Thirty-one said no member of their families had ever joined a prepaid health plan.
- Four persons said they had joined a plan before. In each case, the plan they named was Kaiser.

4. *Why did you decide to stay on Medi-Cal? (Asked when appropriate)*

- Fourteen decided to stay with their present providers.
- Eight said they were able to find a doctor who takes Medi-Cal when they needed care.
- Only two said the plan "didn't sound good" after they had been given more information by the plan.
- One said she was not happy with her present provider but she wanted to stay with him because he and her nursing doctor had "some kind of group deal" and "good doctors are hard to find that will take Medi-Cal cards."

5. *Why did you decide not to join a prepaid health plan? (Asked when appropriate)*

- Fourteen people said they could not continue to see their doctors.
- Four said the facilities were located too far away from their homes.
- Four said transportation was a problem.
- One person didn't like the presentation by the plan.

6. *You asked for information about enrollment in a prepaid health plan. What contact did you have with the plan? (Asked when appropriate)*

- Fourteen were sent information in the mail.
- Three received phone calls from the plan.
- Two people called the plan.
- Five people had had no contact at all.
- Three were still waiting to hear from the plan. (They were given the plan's phone numbers by the interviewer.)
- Two couldn't remember the name of the plan about which they had requested more information. (The interviewer reminded them of their choice and gave them the plan's telephone number.)
- One person was not eligible.

In addition to the telephone interviews of those who did not enroll, calls were made to verify enrollments resulting from the mailing. The form used has thirteen questions directed toward the beneficiary's understanding of enrollment in a prepaid health plan.

The key questions are tabulated below for the small sample interviewed:

1. *First, I want to be sure you understand that you have enrolled yourself (and _____), if anyone else in the family) in a prepaid health plan?*

   All respondents understood they had joined a plan. They all said they knew what they were doing when they filled out the form.

2. *Has anyone from the health plan called or come to see you to ask if you had any questions about services?*

   - Eight people said yes.
   - Seven had had phone verification.
   - Only one had no contact due, evidently, to her moving almost immediately after she enrolled.

3. *What did you think you had to do when you got the mailing?*

   - Five knew it was to get more information.
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   - Four people couldn't find a doctor who would take their Medi-Cal cards.
   - Four others said the plan "sounded good."
   - One said the plan system "sounded easier."
   - One person reported having to wait too long in the doctor's office.
   - One said, "You can't find good services from doctors who will take Medi-Cal people."

6. *Has anyone in your family ever joined a prepaid health plan before?*

   Responses totalled one yes and seven no.

7. *What is your current address?*

   All were matches except for the one who had moved out of the service area.

8. *Have you received a plan booklet explaining the services available?*

   Again, the only no was the one person who had moved.

9. *Do you understand that joining _____ was completely voluntary and that you don't have to enroll to keep your VA or local care?*

   Everyone, seven, answered yes except one person. (This response was referred to the contract manager.)

10. *Do you understand that you signed up for a period of one year, but that you can get out for any reason during the 5-day grace period?*

    All eight people said they understood.

11. *Did anyone ask to see if you are under a doctor's care?*

    - Six responded no.
    - Two said yes. (These responses were referred to the contract manager.)

12. *Do you understand that you cannot go back to your current doctor unless he is in the plan's list?*

    Everyone (eight) said yes.

A Report on the Pretest of Marketing/Enrollment Demonstration Instruments

December 1980

This is a product of the Prepaid Health Research, Evaluation and Demonstration (PHRED) Project. PHRED is supported by an HEW grant (No. 96-P-90299/9-02) to the California Department of Health Services.

Contra Costa Pretest Report

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I. Summary

This report discusses materials and procedures designed for the marketing/enrollment demonstration of the PHRED Project, and their operational testing prior to full usage in all demonstration sites. The purpose of the pretesting was to determine the practicality of the research design in a real environment, to identify inconsistencies in the data collection instruments, to provide insight into implementation of the demonstrations on a state-wide basis, and to identify those areas of the research design which were either extraneous or inadequate.

PHRED staff gained information in each of these areas. Forms, presentations, and procedures were revised as they progressed through the pretesting stage. The computer program was extensively rewritten to correct an oversight uncovered in the pretest. The field representatives assigned to implement the marketing/ enrollment demonstration received valuable on-the-job training. Finally, concepts which were not yet clear were crystalized and questions were translated into operational sets in the data collection instruments.

II. Introduction

The PHRED Project marketing/enrollment demonstrations for prepaid health plans were designed to test several different information-giving models, in different environments. The first situation encompassed a passive information-giving approach: direct mailing. The second approach centered on the welfare office as a logical place to provide clients with information about their health care options. The third "demonstration method" was the health plans' usual marketing approach, primarily door-to-door solicitation. (Door-to-door marketing, which informs potential enrollees of their option to join a prepaid health plan, is usually practiced by seasoned sales people in a random door-to-door approach, but also outside welfare or food stamp offices.)

Of these three methods, only the two experimental methods, the direct mailing approach and the welfare office method were pretested. The Richmond Social Services Office, in Contra Costa County, was selected as the test site.

The direct mailing approach was a mass mailing to all Medi-Cal eligible families (in all aid categories) residing within the Richmond Social Services district. The mailing package consisted of a cover letter, a descriptive brochure and pamphlet, and a choice card. (See Appendix A) The brochure described the differences between the health maintenance organization concept and the fee-for-service health care system. Inserted in the brochure was a pamphlet offering specific information about the Contra Costa Health Plan. The mailing package also included a pre-addressed, postage-paid choice card, so the clients could

communicate their decisions to the state. The cover letter explained the contents of the package, and requested that the client make a decision.
The Richmond pretest mailing made obvious two major problem areas: there was a flaw in the data processing logic, and there were shortcomings in the structure and format of the choice card.

The initial data processing program had not grouped individuals living in the same household, so the mailing package was sent to every Medi-Cal recipient living in the Richmond service area. Naturally, many families returned several choice cards, one for each member, often with each other's names cross-referenced. The Project immediately revised the data processing program so that it indexed Medi-Cal recipients by address. The Project decided against encoding and data-entering the information received from the pretest mailing, since there were so many inconsistencies in the responses, and no analysis of the data occurred.

The second area requiring modification was the structure and format of the choice card. It became apparent that the postcard structure, although convenient for the mass mailing operation, was too small to accommodate legible responses and complete information. It also became necessary to add an additional choice category to the card. Initially, clients were offered a choice between a fee-for-service card and enrolling in the HMO. Many pretest mailing comments indicated that some clients were willing to learn more about HMOs, but only if they could retain their Medi-Cal cards while doing so. Therefore, a category of choice "to learn more about HMOs" was added.

As mentioned above, the identification of the serious flaw in the data processing program obviated in-depth analysis of the pretest mailing data. What was learned from the mailing has been reported in this introduction, and, therefore, the remainder of this workpaper will be devoted to the other pretested method, the welfare office presentations.

III. Preparation

III-A. Pretest Model

Five different media approaches were used in the welfare office demonstrations. Welfare offices are the only single location through which the majority of HMO-eligible clients must pass. They, thus, are logical places to provide clients with information on health care options, and to encourage a choice among the options. The five different approaches planned to be demonstrated by the project were: 1) provide clients with written materials only; 2) show clients a film presentation in combination with written materials; 3) have a County eligibility worker make a presentation and furnish the written

materials; 4) have an HMO representative make a presentation and furnish the written materials; and 5) have a representative from the State make a presentation and furnish the written materials.

The approach selected for pretesting was for a State representative to make the presentation and encourage the client to make a choice. This variant was chosen for a variety of reasons: first, it was easier to train PHRED staff in the observation techniques needed for the pretest, than it would have been to train others not as close to the Membership Studies component of the Project. Second, PHRED Staff more easily were able to alternate the data collection instruments, (i.e., change the process and procedures as necessary), in order to observe their acceptability. This would have been much more difficult to accomplish had PHRED been using staff under indirect control. Third, the PHRED field staff were new to the Project, and the hands-on experience of providing the materials and working in the welfare office environment was expected to be a valuable learning tool.

Besides using the pretest as a learning laboratory for PHRED field staff, it was also important to watch the process flow which had been designed for the County. Prior to implementation at any of the demonstration sites, a PHRED team surveyed the site and developed a theoretical model describing how the presentation could be integrated with the on-going eligibility determination process. The pretest provided the opportunity to observe the theory put into practice. Appendix B describes the processes used at that time.

Finally, the pretest allowed the data collection instruments to be tested for acceptability, inconsistencies, and omissions. Four separate instruments, which will be discussed further in Section IV (A), were used.

III-B. Site Selection

The pretest instruments and other preparatory work were completed in February, 1979. At that time, negotiations were in process with several counties, but only Contra Costa County had actually already agreed to participate in the Membership Studies marketing/enrollment demonstrations. Contra Costa County was a good location to pretest the demonstrations, since two sites, later to be used in the full demonstration, were located there. Contra Costa County is geographically close to the PHRED Project offices in Sacramento, but distant enough to indicate field communication problems which might arise. The County operates its own prepaid health plan, and County Social Services staff required little informational training to acquaint them with the Project.

III-C. Participants

The PHRED Membership Studies field representatives were the principal administrators of the pretest. Field reports from the representatives technical support staff, and County staff were involved as observers, and, in some cases, administrators. Applicants for public assistance under the AFDC Program in the Richmond and Pittsburg Social Services Offices constituted the sample population.

IV. Operation

IV-A. Data Collection

Data were collected over a two and one-half week period from March 1, 1979 to March 16, 1979. Four instruments were used to gather information:

1. Basic Information Form (BIF): This form collected demographic information about the client; the County completed the portion about the client's eligibility status at the time of application. (Appendix D)

2. Presentation Information Form (PIF): This form was designed to assess the clients knowledge of the prepaid health system concept, prior to the presentation of information. It was used in conjunction with the Choice Information Form (CIF). (Appendix F)

3. Choice Information Form (CIF): This form was designed in both long and short versions. The long version included questions designed to assess the client's comprehension of the information just presented. It was felt that this approach should be pretested, since it could provide immediate, reliable data. Discussions with the County indicated that clients would not "sit still" long enough to complete a lengthy questionnaire. Therefore, PHRED staff also prepared a short version of the CIF, which was used with subsequent phone follow-up interviews, in order to assess the client's comprehension of the information. (Appendix H)

4. Phone Follow-up Information Form (PFIF): This form was designed for use with the short version of the CIF. There was concern that clients who had been available in the welfare office at the time of the demonstration would not be available later via telephone. But, if clients refused to complete the long version of the CIF, as County staff predicted, it would also be necessary to pretest this approach. (Appendix J)

The procedures which were used are described in Appendix B. It is important to note that the placement of the demonstration encounter was varied, the verbal presentation was amended as staff learned of omissions or developed clarifications, the usage of the various forms was altered, and presenters were changed so that each field representative could benefit from the experience.

IV-B. Data Analysis

Taking the percent "correct" for five questions of average difficulty, the items showed an average gain of six points from pretest to post-test (from intake to phone follow-up, a period of about 2 weeks).

The five questions (Appendix H-4) were as follows:

1. True False Both regular Medi-Cal and prepaid Medi-Cal provide basic health care at no cost to you.

2. True False People using regular Medi-Cal must find their own doctors.

3. True False Prepaid health plans are part of Medi-Cal.

4. True False If you are using prepaid Medi-Cal, you must go to that plan's facilities except in emergencies when you can't get there.

5. True False People who are eligible for Medi-Cal may choose between regular Medi-Cal and prepaid Medi-Cal.

The following table displays the five questions with pre- and post-testing comprehension scores, showing increases for all items except question 3, between the pretest and post-test administration of the questions. From this, it was apparent that some learning was occurring through the information-giving process.

Figure 1.

	1	2	3	4	5	Average
PRE	.77	.72	.63	.79	.81	74
POST	.80	.84	.55	.89	.95	80

Key:

1 = Care at no cost
2 = Find own doctor
3 = PHP part of Medi-Cal
4 = Same facilities
5 = Choose

V. Problems in Data Collection and Remommendations for Control

The final section of this report delineates specific problems which were encountered in the data collection effort of the pretest and recommendations to control or resolve those problems. Data collection instruments and procedures were revised to more effectively mesh with the on-going processes of the welfare office while maintaining the research design of the marketing-enrollment demonstrations. In concluding this report, the following variables are discussed: size of applicant pool, length of instruments, placement of the presentation, and amount of applicant time to preview the materials.

V-A. Size of Applicant Pool

In order to have reliable data, the research design of the marketing/-enrollment studies required, that for each method, the presentation should be given to 100 clients who were eligible for enrollment in a prepaid health plan. It was thought that the required sample size could be obtained by presenting information to 150 clients per method (assuming that 30 percent of the clients were ultimately deemed ineligible for Medi-Cal and, therefore, ineligible to enroll in a prepaid health plan). In order to see the required 150 clients per method, it would not be necessary to give presentations to every person who applied for public assistance at the social services office. For the pretest, a schedule was designed to allow for a presentation to every fifth client of certain designated eligibility workers.

However, the Social Services Offices experienced a very high rate of cancelled/missed appointments, and seeing every fifth client did not produce the required sample size. Therefore, the schedule was modified so that a greater number of client appointments per eligibility worker were referred for a presentation.

V-B. Length of Forms

The pretest findings did support the County staff's claim that the long forms would be unmanageable in the social service office environment. Once clients realized that completion of the form was not required in order to obtain cash-grant assistance, interest rapidly waned. It was therefore decided to discard the lengthy Choice Information Form (CIF), (sacrificing immediate access to the client), and to adopt the short version of the CIF, with comprehension questions placed in the phone follow-up interviews. (Appendix H)

V-C. Placement of the Presentation

It was quite apparent that placement of the presentation in the eligibility determination process was very important to the successful collection of data. In order to allow the eligibility determination process to screen out those clients who were most likely ineligible, the presentation could not be placed too early in the process. This reduced the amount of unusable data which would be collected.

The pretest made clear that clients were very unresponsive to the presentation when made in conjunction with the eligibility worker interview. Generally, interviews for AFDC eligibility application consume 45 minutes to over one hour. When coupled with an additional 20 minutes (using the short CIF version) or 35 minutes (using the long CIF version), clients became either listless or hostile. Therefore, every attempt was made at all demonstration sites to place the presentation/-choice encounter prior to the AFDC eligibility interview despite the risk of subsequent determination of ineligibility.

V-D. Time to Preview Materials

In the pretest, clients were not sent information in advance of the presentation encounter. PHRED field representatives, therefore, were required to spend more time explaining the program to clients than was necessary. During the demonstrations, clients were provided with as much lead time as possible, so they could review the dual-choice materials prior to reaching the encounter situation.

Appendix A: Mailing Letter, Brochure, and Choice Card

STATE OF CALIFORNIA — HEALTH AND WELFARE AGENCY

EDMUND G. BROWN JR., *Governor*

DEPARTMENT OF HEALTH SERVICES
744-P STREET
SACRAMENTO, CA 95814
(916) 322-4616

(Véase el otro lado para la versión en espanol)

Dear Medi-Cal Beneficiary:

You can make a choice about your health care. You may continue to receive your benefits with your stickers--from the county hospital or from any private doctor or other provider who will accept your Medi-Cal card. Or you may join a Medi-Cal prepaid health plan* which contracts with the State of California to provide all medically necessary care to eligible Medi-Cal recipients who choose to enroll.

The information enclosed with this letter will help you select the type of health care which best suits your personal needs and those of your family. If you decide to enroll in or find out more about a prepaid health plan, you may call the health plan directly at the phone number listed on the information sheet, or you may send the stamped postcard back to the Department of Health Services and we will ask the health plan to contact you. You will remain eligible for free Medi-Cal services whatever you decide, as long as you are eligible for aid.

We want to be sure that you have all the information you need to make your choice. If you have any questions about the information or this letter, you may call the Department of Health on our toll-free line (no charge to you), 1-800-952-5528. I encourage you to think it over carefully and make the decision that will provide the best health care service for you and your family.

Sincerely,

Elisabeth H. Lyman

Elisabeth Lyman
Deputy Director
Medical Care Standards Division
Department of Health Services

Enclosures

* "Prepaid" means paid for, in advance (for you) by the State. You have no costs for Medi-Cal health care under either system.

(SELF-ADDRESSED CARD–MAIL BACK TO STATE DEPARTMENT OF HEALTH SERVICES–NO STAMP NECESSARY)

(TARJETA CON DIRECCIÓN–DEPOSITE EN EL CORREO AL DEPARTAMENTO DE SERVICIOS DE SALUD–NO NECESITA ESTAMPILLA)

Here is the Choice: (Please give information below for each family, including yourself)

Aquí es lo que escojí: (Por favor denos información, abajo para cada miembro de su familia, incluyendose usted)

Name: Last, First, Middle *Nombre: último, primero, en medio*	Relationship to You? *¿Relación a usted?*	Social Security Number *Número de Seguro Social*	Sex *Sexo*	Birthday: Mo./Day/Yr. *Fecha de nacimiento: Mes/Día/Año*	PHP? *¿PHP?*	Card? *¿Tarjeta de Medi-Cal?*

If you have chosen the PHP, please check the box by the plan's name below and tell us how you want to be contacted: ☐ Home Visit ☐ Telephone call from plan

☐ Contra Costa County Health Services' Key Plan

Si usted escojío el PHP, por favor marque al cuadro que tiene el nombre del plan y díganos como se puede poner en contacto con usted. Por:

☐ *Visita en su casa o* ☐ *Teléfono del plan*

☐ *El Plan de Llave de Servicios de Salud del Condado de Contra Costa*

Print Name *(En letras de molde, su nombre)*	Sign *(Firma)*	Date *(Fecha)*	Phone *(Teléfono)*

CONTRA COSTA COUNTY MEDICAL SERVICES' KEY PLAN

The Key Plan, sponsored by Contra Costa County Medical Services, is an organization of health professionals and facilities that provides a wide variety of services to approximately 5,000 members of the community. The plan's goal is the restoration and maintenance of its members' health—taking care of people when they are sick and helping them keep well. The State of California has contracted with the Key Plan to provide care to individuals receiving Medi-Cal benefits who choose to enroll in the plan.

Key Plan offers its members a family doctor of their choosing, specialty physicians, pharmacy, laboratory, X-ray, family planning, and other outpatient services at locations throughout the county.

El Plan Llave de los Servicios Médicos del Condado de Contra Costa

El Plan Llave de los Servicios Médicos del Condado de Contra Costa es una organización de profesionales de salud, que proporcionan una gran variedad de servicios a aproximadamente 5,000 miembros de la comunidad.

El propósito de este plan es la restauración y manutención de la salud de sus miembros—dando cuidado a las personas que estan enfermas y concentrando en la salud futura. El Estado de California ha contrada con el Plan Llave para que proporcione servicio a individuos que reciben beneficios de Medi-Cal, los quienes escojan a enrollar en este plan.

El Plan Llave ofrece a sus miembros que escojan a su médico de familia, médicos especialisados, farmacia, laboratorio, rayos X, servicios para planear su familia, y otros servicios para pacientes ambulantes en sitios por todo del condado.

What's the difference

BETWEEN A MEDI-CAL CARD AND A MEDI-CAL HEALTH MAINTENANCE ORGANIZATION (HMO-PHP)?

¿Cuál es la diferencia

ENTRE UNA TARJETA DE MEDI-CAL Y UN PLAN DE MEDI-CAL (PHP-HMO)?

Appendix B: Pretest Scenario

COUNTY: CONTRA COSTA
NEW APPLICANT

CHOICE OFFERED DURING INTAKE

APPLICATION PROCESS	DEMONSTRATION PROCESS(STATE REPRESENTATIVE PRESENTATION	FORMS
1. Applicant reports to receptionist. Applicant is given a CA-1 to fill out.		Basic Information Form (BIF) State Brochure
2. Applicant fills out forms and returns them to receptionist.		
3. Receptionist forwards forms to Data Processing, where applicants information is checked to see if there is any current or History files.		
4. Applicant forms are then placed in Screening box. Applicants name and the time are entered in the screening daily log.		
5. Intake screener calls applicants for interview. During interview potential classification is determined.		
6. Screener then calls receptionist for appointment. If applicant is AFDC, screener will indicate this to receptionist.		
7. At the time the appointment is made if the applicant is placed in one of the time slots that have been designated as PHRED, the receptionist will schedule the interview 15 minutes earlier than usual and notify the screener that the applicant is PHRED designated.		

NEW APPLICANT — CHOICE OFFERED DURING INTAKE

APPLICATION PROCESS	DEMONSTRATION PROCESS(STATE REPRESENTATIVE PRESENTATION)	FORMS
8. If a client is PHRED designated the screener will include a Basic Information Form to the regular package of forms given the client. 9. The screener will also give the client a State Brochure and ask them to review it prior to their scheduled intake interview. 10. Applicant leaves.	A. client checks in with receptionist B. Receptionist notifies State Representative C. State representative calls client. Reviews BIF. D. State representative gives Dual Choice Presentation. E. Gives client Choice Card asks them to fill it out and sign it. F. State representative fills out PCI and demonstration section of BIF. G. Client returned to waiting room. H. State representative assembles all PHRED forms, staples them together and retains them. I. If client is late for interview, State representative will give presentation after E.W. interviews.	Choice Card Presentation & Choice Information Form (PCI)

Appendix C: Field Representative Reports

State of California

Department of Health Services

Memorandum

To : John Hanretty

Date : 18 March 1979

Subject: Pittsburg Pre-test 3/1 Through 3/16

Telephone: ATSS ( )
( )

From : Bob Peterson

General

Clients seen from March 1 through March 8 did not receive the brochure or Basic Information Form prior to the demonstration. From March 9 through 16, if PHRED designated, were being given a BIF and brochure by the screener. All clients who have been issued a BIF have had the information section completed and had completed the true or false section. Several clients have had to be asked to complete question 14 ("What do you think is the most important thing Medi-Cal should do for people?"). The most asked question is "What do you mean?". The Presentation Information Form asks if the client has received aid in the last six months. Does this mean any kind of aid or AFDC? What about aid from another state? Another county?

To date only one client has been incapable of filling out the form. Those clients who were given BIFs by the screener to fill out and return at the time of their intake interview all returned with the froms completed.

During the demonstration clients exhibited an interest. The majority of the questions related to the local PHP, rather than eligibility. To date only two clients expressed any degree of negativeness, and that was that they refused to complete the survey section of the BIF. I have not met with any hostility from clients or staff.

Staff had several questions regarding client service (will doctor's ever be required to carry a percentage of Medi-Cal patients? Will the HMO structure insure quality care for PHP clients?). Eligibility workers, as well as staff, have observed the time involved presenting the demonstration and have remarked that it doesn't seem as though it will cause any change or hinder the current workload. By observing the operation and talking with their clients they are now assured that the demonstration is a dual-choice and not a PHP sales pitch. This seems to have made a big difference in their overall attitudes.

Intake

Due to no shows and cancellations, I increased intake appointments from three to four each day to assure meeting necessary quotas. There is no problem with this. Having the county supply a copy of the general one is a benefit that should be utilized whenever possible. It allows the demonstrator to have the choice information and presentation forms nearly completed prior to seeing the client, allowing more time for presentation, and the client seems relieved that they don't have "another batch" of forms to complete. It is extremely detrimental when a client shows up late and the demonstration has to follow the intake interview, clients seem to be "wrung out". When this occurs the county makes

sure we see the clients, as they route them to me, and inform me where to send them after I've completed the demonstration. If a client is late the reception desk always notifies me so that I am aware of the situation.

Redetermination

I have only seen five redeterminations to date during the pre-test. The reason for this is that redeterminations are at a minimum at this time because the majority of the EW's time is currently directed towards food stamp procedure changes, and General Assistance program change orientation. All GA clients are required to come to the office for this orientation. An increase in redetermination interviews is anticipated in the near future. When a redetermination is to be given the dual-choice presentation the worker escorts the client to me, introduces us to each other and advises me if the client is to see someone else following the demonstration.

Forms

There is no problem timewise with the short forms. Clients seem to resist the long forms. The majority of the clients do not make a concertrated effort to complete it. One client just quit in the middle of the questions. Other clients just mark answers to complete it. In view of the fact that the majority of the clients do have telephones, I recommend we do not use the long form, but do a telephone follow-up.

I would like to compliment the staff at Pittsburg. Their attitudes and cooperation have been outstanding.

BP/tb

State of California — Department of Health Services

Memorandum

To : John Hanretty

Date : 18 March 1980

Subject: Contra Costa
Pretest Report
Addendum

From : R. R. Peterson

General Information

Due to a change in our schedule, brochures were not sent out ahead of time nor were clients scheduled 15 minutes early, as we had previously planned. This changed the (our) procedures in that the PHRED presentation cut into the scheduled EW interview time. In order to minimize this, I watched the clients fill out as much of the BIF as they intended to and called them before they read the brochure.

I only saw four clients during the four days I was at Richmond. I was scheduled to see 18. Thirteen were no-shows and one left before the PHRED presentation.

Intakes

Of my three intakes, two were specifically interested in their Medi-Cal benefits. One case was that of a newly pregnant 18-year-old and the other was a non-needy caretaker of a 16-year-old.

Brochure Day

On the first brochure day, March 14, 1979, there were only three BIFs and four choice forms completed. Several factors contributed to this. The brochure only procedure for intake calls for issuing the brochure and necessary forms only to clients who are in for screening. The re-evaluation procedures call for the EW to complete the BIF and the client to complete the CIF in the waiting room after their interview and submit it to the receptionist.

I recommend that all scheduled AFDC visits on brochure day be given the PHRED package and have the EWs collect the CIF at the completion of the interview. The application clerk could continue to issue the BIFs to initial clients. Because we do not know the eligibility status at this time I recommend a BIF be completed on all initial interviews on brochure day.

Conclusion

We simplify the presentation by using only short forms. Increase the number of intake clients to assure meeting minimum project numbers. Revise procedures to involve more clients on brochure day and assure that we are given a daily count of AFDC clients seen for intake or RV.

RP:tl

State of California — Department of Health Services

Memorandum

To : John Hanretty

Date : 18 March 1979

Subject : Contra Costa
Pretest Report

From : Anthony Meeks

Over a period of four days, I had six intake applicants, two redetermination clients and three individuals applying through the brochure method. Only one of the nine read the brochure ahead of time, primarily because it was not mailed out ahead of time. A few did attempt to fill out the forms with two doing a very acceptable job (both we seen under the brochure method). I filled out all of the others while the clients supplied the answers. This was done to speed the presentation time since the clients were not scheduled early and yet had to be seen by their workers.

There were few questions asked about Prepaid Health Plans (PHPs). Most of the clients are familar with the Contra Costa Key Plan either through friends or relatives, personal experience or advertisements.

No one chose to sign up for the Key Plan. There were several stated reasons:

1. Doctor relations--the applicants and clients either had a doctor that took the Medi-Cal card or knew of one through a friend or relative. Also, convience and proximity to the doctor was all important.

   Flexibility in coverage was important also. Some of clients used or will use their Medi-Cal card at the PHP facility and yet keep their private doctor, who accepts it.

2. Familiarity with Medi-Cal--most people are familiar with the Medi-Cal card and the system. They have used it before or have had it explained by someone. This system is known and accepted by many.

3. Key Plan--a few individuals have had either a personal experience with this PHP or word-of-mouth information and were not interested in joining. They felt this system was inferior to the Medi-Cal card in flexibility and distance.

Eighty percent appeared to have either low or slight interest. They were polite and considerate and receptive to my questions. Two clients were disturbed by the questions and forms and by having to set through the presentation (both were redetermination).

Most of the people supplied me with short to terse answers.

The most serious problem with the interview and this system appears to be the number of questions asked and their length. In addition, the questions are repetitious.

Client reactions are gasps, drumming, general boredom, and remarks (i.e., "if you're not my worker, then why am I here"). The last remark is especially interesting since the reason they were speaking to me was explained.

General complaints from welfare office: boxes on the forms are too small.

AM:tl

Appendix D: Bask Information Form (BIF)
(Short and Long Versions)

(office use only)

BASIC INFORMATION FORM (BIF)
SHORT VERSION DRAFT #1

General Instructions: Please complete this form as thoroughly as you can. All items are to be filled in according to the instructions next to them. If there is something you are unsure of or do not understand ask the worker who collects this form for help.

Be sure the blanks for your name, address and phone number are correctly filled in and legibly printed so that your information can be accurately recorded.

1. Name: _____ (print, last, first, middle ibitial)
2. Address: _____ (house number, street or road)
3. Phone Number: (area code) _____ - _____
   _____ (city) _____ (county) _____ (ZIP code)
4. Your Birthdate: _____ (month, day, year)
5. Sex: (check one) 1 ☐ Female 2 ☐ Male
6. Marital Status: (check one)
   1 ☐ Married 2 ☐ Divorced 3 ☐ Separated
   4 ☐ Widowed 5 ☐ Single 6 ☐ Other
7. Ethnic Group Identity: (check one)
   1 ☐ Asian 2 ☐ Black 3 ☐ Filipino 4 ☐ Hispanic
   5 ☐ Native American 6 ☐ White 7 ☐ Other
8. Language Spoken In Home: (check one)
   1 ☐ English 2 ☐ Spanish 3 ☐ Other
9. Highest Grade In School: ☐☐ (enter number)
10. Age Of Youngest Child: ☐☐ (enter number)
11. Number Of Children In Home: ☐☐ (enter number)
12. Age Of Oldest Child: ☐☐ (enter number)
13. Do you have a regular source of health care? 1 ☐ Yes 2 ☐ No

OPINION SURVEY

14. What do you think is the most important thing Medi-Cal should do for people? _____

15. Have you ever heard of Prepaid Health Plans (PHPs)? 1 ☐ Yes 2 ☐ No 3 ☐ Don't Know
16. Have you or a member of your family ever joined a Prepaid Health Plan (PHP)? 1 ☐ Yes 2 ☐ No 3 ☐ Don't Know

Please answer the following questions to the best of your ability. Circle T if you think the statement is TRUE and F if you think it is FALSE.

17. T F Both regular Medi-Cal and prepaid Medi-Cal provide basic health care at no cost.
18. T F People using regular Medi-Cal must find their own doctors.
19. T F Prepaid health plans are not part of Medi-Cal.
20. T F If you use prepaid Medi-Cal you must go to that plan's facilities except in emergencies when you can't get there.
21. T F People who are eligible for Medi-Cal may choose between regular Medi-Cal and prepaid health plans.

SV/[illegible]/26/79

Appendix B

(office use)

BASIC INFORMATION FORM (BIF)
LONG VERSION DRAFT #1

General Instructions: Please complete this form as thoroughly as you can. All items are to be filled in according to the instructions next to them. If there is something you are unsure of or do not understand ask the worker who collects this form for help.

Be sure the blanks for your name, address and phone number are correctly filled in and legibly printed so that your information can be accurately recorded.

1. Name: _____ (print, last, first, middle initial)

2. Address: _____ (house number, street or road)

3. Phone Number: ___ - ___ - ____ (area code)

_____ (city) _____ (county) _____ (ZIP code)

4. Your Birthdate: __ __ __ (month, day, year)

5. Sex: (check one) 1 ☐ Female 2 ☐ Male

6. Marital Status: (check one)

1 ☐ Married 2 ☐ Divorced 3 ☐ Separated
4 ☐ Widowed 5 ☐ Single 6 ☐ Other

7. Ethnic Group Identity: (check one)

1 ☐ Asian 2 ☐ Black 3 ☐ Filipino 4 ☐ Hispanic
5 ☐ Native American 6 ☐ White 7 ☐ Other

8. Language Spoken In Home: (check one)

1 ☐ English 2 ☐ Spanish 3 ☐ Other

9. Highest Grade In School: ☐☐ (enter number)

10. Number Of Children In Home: ☐☐ (enter number)

11. Age Of Youngest Child: ☐☐ (enter number)

12. Age Of Oldest Child: ☐☐ (enter number)

13. Do you have a regular source of health care? 1 ☐ Yes 2 ☐ No

OPINION SURVEY

14. What do you think is the most important thing Medi-Cal should do for people? _____

_____

15. Have you ever heard of Prepaid Health Plans (PHPs)? 1 ☐ Yes 2 ☐ No 3 ☐ Don't Know

16. Have you or a member of your family ever joined a Prepaid Health Plan (PHP)? 1 ☐ Yes 2 ☐ No 3 ☐ Don't Know

Please answer the following questions to the best of your ability. Circle T if you think the statement is TRUE and F if you think it is FALSE.

17. T F Both regular Medi-Cal and prepaid Medi-Cal provide basic health care at no cost.

18. T F People using regular Medi-Cal must find their own doctors.

19. T F Prepaid health plans are not part of Medi-Cal.

20. T F If you use prepaid Medi-Cal you must go to that plan's facilities except in emergencies when you can't get there.

21. T F People who are eligible for Medi-Cal may choose between regular Medi-Cal and prepaid health plans.

(Please turn page and continue)

22. If you or a member of your household is sick, where do you usually go for care? (check box)
1☐ Private Doctor *2*☐ County Clinic *3*☐ County Hospital *4*☐ Emergency Room *5*☐ Other: _____

23. How satisfied are you with the care you receive there? (check box)
1☐ Very Satisfied *2*☐ Satisfied *3*☐ So-So *4*☐ Dissatisfied *5*☐ Very Dissatisfied

24. How many times have you seen a doctor in the last year? (enter number) ☐☐

25. How many times has someone in your household other than yourself seen a doctor in the last year? (enter number) ☐☐

26. How many times have you been hospitalized in the last year? (enter number) ☐☐

27. How many times has someone in your household other than yourself been hospitalized in the last year? (enter number) ☐☐

28. Do you or any of your family need medical care now? (check box) *1*☐ Yes *2*☐ No

Appendix E: Instructional Guide for BIF

BASIC INFORMATION FORM - INSTRUCTIONAL GUIDE

This document will be completed by each client prior to receiving any information or any presentations.

The following account is an item by item description of the data needed for each question on the BIF (long version):

1. NAME:
   A. The respondent should select the appropriate (title) for his/her name from the choices of (1) Ms., (2) Mrs., (3) Miss, (4) Mr.
   B. The respondent should print their entire name in the boxes provided in this order: last, first, middle. A space should be skipped between last and first and between first and middle names.

2. ADDRESS:
   A. The respondent should enter the number of their house or apartment, then the name of their street or road with 1 box skipped between number and street.
   B. City-the respondent should enter the name of the city in which they live.
   C. County-the respondent should enter the name of the county in which they live.
   D. Zip -the respondent should enter all 5 digits of the zip code in which they live.

3. PHONE NUMBER:
   The respondent should enter their phone number in the following order: area code (3 digits); prefix (3 digits); number (4 digits).

4. BIRTH DATE:
   The respondent should enter their birthdate in the following order: month, day, year. Example: June 12, 1947 would be 0 6 1 1 2 4 7.

5. SEX:
   The respondent should indicate their sex in the appropriate box, Female=1; Male=2.

6. MARITAL STATUS:
   The respondent should indicate their current marital status in the appropriate box: Married=1; Divorced=2; Separated=3; Widowed=4; Single=5; and Other=6.

7. ETHNIC GROUP IDENTITY:
   The respondent should indicate their acknowledged ethnic group identity (this question should be considered optional) in the appropriate box: 1=Asian; 2=Black; 3=Filipino: 4=Hispanic; 5=Native American; 6=White; 7=Other.

8. LANGUAGE SPOKEN IN HOME:
   The respondent should indicate the language spoken in their home in the appropriate box: 1=English; 2=Spanish; 3=Other.

9. HIGHEST GRADE COMPLETED IN SCHOOL:
   The respondent should enter their highest grade completed in school: Example: elementary completed 0 8 ; high school completed 1 2 ; College (BA) completed 1 6.

10. NUMBER OF CHILDREN IN HOME:
The respondent should indicate the number of children living at home and for whom they are responsible.

11. AGE OF YOUNGEST CHILD:
The respondent should enter the age of the youngest child at home and for whom they are responsible, in years. Example: if a child is 2 years old, 02 would be entered. If a child is less than 1, enter 00.

12. AGE OF OLDEST CHILD:
The respondent should enter the age of the oldest child at their home and for whom they are responsible in years. Example: if a child is 12 years old, 12 would be entered.
NOTE: IF THERE IS ONLY ONE CHILD IN THE HOME, ENTER AS OLDEST AND LEAVE #11 BLANK. IF CHILD IS UNBORN, ENTER 00.

13. DO YOU HAVE A REGULAR SOURCE OF MEDICAL CARE?
The respondent should indicate if they have a regular source they go to when they or a member of their family has a medical problem.

14. WHAT MEDI-CAL SHOULD DO:
The respondent should indicate what they think is the most important thing Medi-Cal should do for people. Respondent should feel free to use their own ideas and/or suggestions. Do not coach respondent.

15. HEARD OF PHPs:
The respondent should indicate whether or not they have ever heard of HMOs/pre-paid health plans. The "Don't Know" category should be used when the respondent is uncertain of what a PHP is, or can not recall.

16. JOINED A HMO:
The respondent should indicate whether or not they or a member of their household and for whom they are responsible have ever joined a pre-paid health plan. The "Don't Know" category should be used when the respondent is uncertain of what a HMO/PHP is, or can not recall.

17-21

The respondent should indicate whether they think each of these statements are TRUE OR FALSE by circling T or F appropriately. The respondent should be encouraged to answer the questions to the best of their ability but should also be advised that they will not be penalized in any way for not knowing the proper answers. The respondent should not be coached by anyone. These items should be completed prior to the respondent receiving any presentations or written material.

22. SOURCE OF CARE:
The respondent should indicate their most often used source of health care in the appropriate box. If the usual source is not listed, the respondent should check "other" and write in their correct source.
NOTE: Only once source should be indicated.
1= Private doctor someone specific the respondent sees as needed.
2= County clinic-County outpatient ambulatory medical facility.
3= County hospital-County inpatient medical facility.
4= Emergency Room-County emergency facility used as needed.

BIF - Instructional Guide
B3

23. SATISFACTION WITH CARE:
The respondent should indicate how satisfied they are with their current source of care on a scale of 1-5. This should indicate a general or overall satisfaction with the source. Only 1 box should be marked.

24. SELF DOCTOR VISITS IN LAST YEAR:
The respondent should indicate the number of visits they have had to the doctor or their usual source of care within the last 12 months. Example: 2 visits would be indicated as 0 2 .

25. OTHER HOUSEHOLD MEMBER DOCTOR VISITS IN THE LAST YEAR:
The respondent should indicate the number of visits other members of their household (for whom they are responsible) have had to the doctor OR THEIR USUAL SOURCE OF CARE in the last 12 months. There should be 1 total for the entire household, excluding self. Example: 10 visits would be indicated as 1 0 .

26. SELF HOSPITALIZATION IN LAST YEAR:
The respondent should indicate the number of times they have been hospitalized as an inpatient in the last 12 months. DO NOT INCLUDE TRIPS TO THE EMERGENCY ROOM AND/OR CLINICS WITHIN THE HOSPITAL THAT ARE PART OF USUAL SOURCE OF CARE. Example: 1 visit would be indicated as 0 1 .

27. OTHER HOUSEHOLD MEMBERS HOSPITALIZED IN LAST YEAR:
The respondent should indicate the number of times other members of their household and for whom they are responsible have been hospitalized as an inpatient in the last 12 months. DO NOT INCLUDE TRIPS TO THE EMERGENCY ROOM AND/OR CLINICS WITHIN THE HOSPITAL THAT ARE PART OF USUAL SUURCE OF CARE. There should be 1 total for the entire household, excluding self. Example: 6 visits would be indicated as 0 6 .

28. NEED MEDICAL CARE NOW:
The respondent should indicate whether or not they or a member of their household and for whom they are responsible need medical care at the present time.

Appendix F: Presentation Information Form (PIF)

Hamilton

PRESENTATION INFORMATION FORM (PIF)

General Instructions: Please complete this form as thoroughly as possible for each client, regardless of type of presentation. If there is something you are unsure of refer to the instruction manual or check with State personnel.

Be sure the blanks for name, Social Security and Medi-Cal numbers are correctly filled in and legibly printed.

Presentation: If client received a presentation be sure to accurately record the start and finish times, and the total presentation time in minutes.

No Presentation: If client receives brochure only, items 12-14 should be left blank, and only items 15-16 should be completed.

FOR COUNTY PROJECT USE ONLY

1. Client's Name: (check one) ☐ Ms ☐ Mrs ☐ Miss ☐ Mr
   _____
   (print, last, first, middle initial)
2. Social Security Number: ___ - __ - ____
3. Medi-Cal Number: _____
4. Office (site location): 1 ☐ Pittsburg 2 ☐ Richmond
5. Type of Case: (check one) 1 ☐ Intake 2 ☐ Other (Re-evaluation)
6. Has client received aid in the last 6 months?
   1 ☐ Yes 2 ☐ No
7. Was printed material given to client on the day of the presentation? 1 ☐ Yes 2 ☐ No (explain) _____
   _____
8. Did the client require a translator to understand the written materials? 1 ☐ Yes 2 ☐ No
9. Date of Presentation: __ - __ - ____
   mo day year
10. Presentation Setting: 1 ☐ Individual Presentation
    2 ☐ Group Presentation 3 ☐ Other
11. Type of Presentation:
    1 ☐ Printed Material Only 4 ☐ EW (County)
    2 ☐ PHP Representative 5 ☐ AV (Film)
    3 ☐ State Worker 6 ☐ No Presentation (Explain Below)
    _____
    _____
12. Presentation Started: (clock time) __:__ am/pm
13. Presentation Completed: (clocktime) __:__ am/pm
14. Total Presentation Time: (in minutes) ___
15. Total County Eligibility Worker Time: (in minutes) ___
16. Total County Clerical Time: (in minutes) ___

NOTES/COMMENTS _____

2/26/79

Appendix G: Instructional Guide for PIF

PRESENTATION INFORMATION FORM (PIF) INSTRUCTIONAL GUIDE

This document is intended for use by County, State or Plan representatives and will be filled out on every client who receives a presentation. If a client should have received a presentation and did not, the form should be completed to the extent possible with an explanation in item #11.
The following is an item by item description of the data needed on the PIF:

1. NAME: A. The staff member should select the appropriate title for the respondent's name from the choices of (1) Ms, (2) Mrs, (3) Miss, (4) Mr
   B. The staff member should print the respondent's entire name in the boxes provided in this order: last, first, middle. A space should be left between last and first and between first and middle names.

2. SOCIAL SECURITY NUMBER: The staff member should enter the respondent's Social Security Number as it appears on their Social Security card with one number per box.

3. MEDI-CAL NUMBER: The staff member should enter the respondent's Medi-Cal number as it appears on other official documents with one number per box.

4. OFFICE: (site location) The staff member should indicate the location of where the presentation occured with 1=Pittsburg and 2=Richmond.

5. TYPE OF CASE: The staff member should indicate the type of case involved with 1=Intake and 2=Other (renewal, reinvestigation, redetermination).

   AID IN LAST SIX MONTHS: The staff member should indicate (to the best of their knowledge) whether or not the client has received aid in the last 6 months. This should also include aid in any other county other than the current one. If the client has received aid in this or another county within the last 6 months, then code 1=Yes; if not, 2=No.

7. PRINTED MATERIAL BEFORE DAY OF PRESENTATION: The staff member should indicate (to the best of their knowledge) whether or not the client was given written information prior to the day of the presentation. 1=Yes, 2=No

8. TRANSLATOR NEEDED: The staff member should indicate whether or not the client needed a translator to read or understand the written materials. 1=Yes, 2=No

9. DATE OF PRESENTATION: The staff member should enter the date of the presentation in the following order: month, day, year. Two spaces should be used for each segment. Example: March 1, 1979 would be [0][3][0][1][7][9] .

10. PRESENTATION SETTING: The staff member should indicate the type of presentation setting the client experienced. 1=Individual presentation (materials were given/ explained to client on a one-to-one basis) 2=Group presentation (materials were given/explained to client as part of a group process) 3=Other (please list).

11. TYPE OF PRESENTATION: The staff member should indicate the type of presentation given to the client. 1=Printed material only 2=County eligibility worker 3= PHP representative 4=Audio-visual (film) 5=State worker 6=No presentation. If no presentation was made, please explain why.

ITEMS 12-14 SHOULD BE FILLED IN ONLY WHEN A CLIENT RECEIVES A PRESENTATION BY COUNTY, STATE OR PHP PERSONNEL. IF CLIENT RECEIVES WRITTEN MATERIAL ONLY, OR A-V, THESE QUESTIONS SHOULD BE LEFT BLANK.

12. PRESENTATION STARTED: The staff member should enter the clock time at which the presentation started. Example: 10:15 in the morning would be [1][0] : [1][5] (AM) PM.

13. PRESENTATION COMPLETED: The staff member should enter the clock time at which the presentation ended. Example: 10:30 in the morning would be [1][0] : [3][0] (AM) PM.

14. TOTAL PRESENTATION TIME: The staff member should enter the total presentation time in minutes. This should be the difference in minutes of #12 from #13. Using the example from above: [0][1][5] minutes.

15. TOTAL COUNTY ELIGIBILITY WORKER TIME: The staff member should enter the total EW time spent on the presentation in minutes. Example: 5 minutes would be [0][0][5] .

16. TOTAL COUNTY CLERICAL TIME: The staff member should enter the total county clerical time spent on the presentation in minutes. Example: 10 minutes would be [0][1][0] .

Appendix H: Choice Information Form (CIF)
(Short and Long Versions)

Hanielly

CHOICE INFORMATION FORM (CIF)

General Instructions: Please complete this form as thoroughly as you can. All items are to be filled in according to the instructions next to them. If there is something you are unsure of or do not understand ask the worker who collects this form for help.

Be sure the blanks for your name, address, phone and Social Security numbers (and Medi-Cal number if you have one) are correctly filled in and legibly printed, so that your choice can be accurately recorded.

1. Name: _____ (print, last, first, middle initial)

2. Address: _____ (house number, street or road)

3. Phone Number: ___ - ___ - ____ (area code)

4. _____ (city) _____ (county) _____ (ZIP code)

TO THE STATE DEPARTMENT OF HEALTH SERVICES: I have made a choice between receiving a regular Medi-Cal card and enrolling in a Medi-Cal prepaid health plan. If I (we) are eligible for Medi-Cal, I wish to receive health care benefits for myself and the family members for whom I am authorized to sign as I have indicated in the box below.

PLEASE FILL IN THE FOLLOWING INFORMATION ABOUT YOU AND YOUR FAMILY:

	5. Name: last, first initial, middle initial		Relation 6. to you	7. P	8. A	9. Social Security number	10. Medi-Cal number	11. Birthdate month day, year	12. Sex
A									
B									
C									
D									
E									
F									

13. Do you have any other health insurance?
1☐ Yes 2☐ No Company: _____

14. Policy Number: _____

15. Persons Covered:

_____ _____
_____ _____
_____ _____
_____ _____

16. Please explain here if your choice is not the same for all family members: _____

_____

If you have chosen the PHP, please check the box by the plan's name below and tell us how you want to be contacted:

17. ☐ Contra Costa County Health Services' Key Plan (plan chosen)

18. 1☐ Home visit 2☐ Telephone call from plan

Print Name: _____ Sign: _____ Date: _____

SW/9 2/26/79

CHOICE INFORMATION FORM (CIF)

General Instructions: Please complete this form as thoroughly as you can. All items are to be filled in according to the instructions next to them. If there is something you are unsure of or do not understand ask the worker who collects this form for help.

Be sure the blanks for your name, address, phone and Social Security numbers (and Medi-Cal number if you have one) are correctly filled in and legibly printed, so that your choice can be accurately recorded.

1. Name: _____ (print, last, first, middle initial)
2. Address: _____ (house number, street or road)
3. Phone Number: ___ - ___ - ____ (area code)
4. _____ (city) _____ (county) _____ (ZIP code)

TO THE STATE DEPARTMENT OF HEALTH SERVICES: I have made a choice between receiving a regular Medi-Cal card and enrolling in a Medi-Cal prepaid health plan. If I (we) are eligible for Medi-Cal, I wish to receive health care benefits for myself and the family members for whom I am authorized to sign as I have indicated in the box below.

PLEASE FILL IN THE FOLLOWING INFORMATION ABOUT YOU AND YOUR FAMILY:

	5. Name: last, first initial, middle initial			Relation 6. to you	7.	8.	9. Social Security number	10. Medi-Cal number	11. Birthdate month, day, year	12. Sex
A										
B										
C										
D										
E										
F										

13. Do you have any other health insurance?
1 ☐ Yes 2 ☐ No Company: _____
14. Policy Number: _____
15. Persons Covered:
_____ _____
_____ _____
_____ _____
_____ _____

16. Please explain here if your choice is not the same for all family members: _____
_____

If you have chosen the PHP, please check the box by the plan's name below and tell us how you want to be contacted

17. ☐ Contra Costa County Health Services' Key Plan (plan chosen)
18. 1 ☐ Home visit 2 ☐ Telephone call from plan

Print Name: _____ Sign: _____ Date: _____

2/26/79

(Please turn page to continue)

ote: PHP - If you choose to enroll in a Prepaid Health Plan (PHP) make sure you complete items 19-22.

OR

Regular Medi-Cal - If you choose regular Medi-Cal and not a Prepaid Health Plan make sure you complete items 23-26.

F YOU CHOSE TO ENROLL IN A PREPAID HEALTH PLAN (PHP), PLEASE ANSWER THESE QUESTIONS:

9. What would you say is the main reason you decided to enroll? _____

_____

0. Was it important to you that all of the Medi-Cal services are arranged for you by the plan? *1* ☐ Yes *2* ☐ No

1. What other features of the plan were important to you? _____

_____

2. What would you say are the most important things PHPs should do for you? _____

_____

_____

F YOU CHOSE REGULAR MEDI-CAL, PLEASE ANSWER THESE QUESTIONS:

3. What is the main reason you decided to stay with regular Medi-Cal? _____

_____

4. Was it important to you to be able to choose your own doctor? *1* ☐ Yes *2* ☐ No

5. What other features of regular Medi-Cal were important to you? _____

_____

6. What would you say are the most important things Medi-Cal should do for you? _____

_____

_____

(Please turn page and continue)

BELOW ARE SOME QUESTIONS ABOUT MEDI-CAL THAT ARE IMPORTANT FOR PEOPLE TO UNDERSTAND. PLEASE ANSWER THEM TO THE BEST OF YOUR ABILITY.

MARK THE FOLLOWING QUESTIONS T FOR TRUE OR F FOR FALSE:

1. T F Pre-paid health plans are part of Medi-Cal.
2. T F Both regular Medi-Cal and Pre-paid Medi-Cal provide basic health care at no cost to you.
3. T F People who are eligible for Medi-Cal may choose between regular Medi-Cal and Pre-paid Medi-Cal.
4. T F Sometimes PHPs offer extra services that regular Medi-Cal doesn't.
5. T F People who use regular Medi-Cal have to use the same doctor all the time.
6. T F If you are using Pre-paid Medi-Cal, you must go to that plan's facilities except in emergencies when you can't get there.
7. T F People on Medi-Cal who go to PHPs are guaranteed health care by the plan.
8. T F PHPs allow their members to go anywhere they want for health care.
9. T F People using regular Medi-Cal must find their own doctors.
10. T F It may take up to 45 days to disenroll from a pre-paid health plan

ANSWER THE FOLLOWING QUESTIONS BY CIRCLING THE LETTER YOU THINK IS RIGHT:

11. If you are a member of a pre-paid health plan
    A. You must go to that plan for care except in emergencies.
    B. You can still see your old doctor.
    C. You can go to any doctor who takes Medi-Cal patients.

12. If a person who belongs to a PHP tries to disenroll, they will find out that
    A. They don't have to tell anyone, they just stop going to the PHP.
    B. It will take up to 45 days to go through the disenrollment process.
    C. It usually takes only 2-3 days to disenroll.

13. Mrs. Jones is the sole supporter for her four young children. She has been granted AFDC and is curious to find out about medical benefits. This means that Mrs. Jones...
    A. is eligible for regular Medi-Cal.
    B. is eligible to join a PHP.
    C. may choose to enroll in either regular Medi-Cal or a PHP.

14. One type of person who might like joining a pre-paid health plan is someone who....
    A. has a regular family doctor.
    B. can't find a doctor who takes Medi-Cal patients.
    C. never goes to the doctor.

15. Sally says that since she is new in town and doesn't have a regular doctor, its probably a good idea for her to join a pre-paid health plan. Do you think....
    A. Sally is probably right because she will know how and where to get care.
    B. Sally is probably wrong because all doctors take Med Cal patients and it would be easy to find one.
    C. Sally is probably wrong because most people don't need a regular doctor anyway.

16. If you were trying to choose between joining a pre-paid health plan or using regular Medi-Cal, what is the most FAIR suggestion that someone could say to you?
    A. "It really isn't important, why don't you flip a coin?"
    B. "Actually there are good points and bad points about both, it depends upon your own needs."
    C. "Everybody should use regular Medi-Cal, that's what I do."

Appendix I: Instructional Guide for CIF

Prototype
2.1

CHOICE INFORMATION FORM (CIF)--INSTRUCTIONAL GUIDE

This document will be completed by each client prior to receiving any information or any presentations. The following is an item by item description of the data needed for each question on the CIF (long version).

1. NAME: The respondent should print their entire name in the spaces provided in this order: last, first, middle initial. A space should be skipped between last and first and between first and middle initial.

2. ADDRESS: (house number, street or road) The respondent should enter the number of their house or apartment, then the name of their street or road with one box skipped between number and street.

3. PHONE NUMBER: The respondent should enter their phone number in the following order: area code (three digits); prefix (three digits); number (four digits).

4. ADDRESS: (city, county, ZIP code) (A) City: the respondent should enter the name of the city in which they live. (B) County: the respondent should enter the name of the county in which they live. (C) ZIP code: the respondent should enter all five digits of the ZIP code in which they live.

5A-F NAME: The respondent should enter their name in line 5A and the names of their family members in 5B through 5F in the following order: last name, first initial, middle initial. A space should be skipped between the last name and first initial and the first and middle initials. IF THE PESPONDENT HAS MORE THAN FIVE FAMILY MEMBERS, PLEASE ATTACH ADDITIONAL CIFs WITH ITEMS 5 THROUGH 12 FILLED IN ONLY.

6A-F RELATION TO YOU: The respondent should enter their relationship with the person named. Line 6A has been filled in as "self". Examples of other appropriate responses: son, daughter, neice, etc.

7A-F P&P CHOICE: The respondent should indicate whether they want to enroll themselves and/or their family members in a P&P by checking this box as appropriate.

8A-F CARD CHOICE: The respondent should indicate whether they want a regular Medi-Cal sticker card for themselves and/or their family members by checking this box as appropriate.

9A-F SOCIAL SECURITY NUMBER: The respondent should enter their and their family members' Social Security numbers as they appear on their Social Security cards, IF AVAILABLE.

10A-F MEDI-CAL NUMBER: The respondent should enter their and their family members' Medi-Cal numbers as they appear on other official documents, IF AVAILABLE.

11A-F BIRTHDATE: The respondent should enter their and their family members' birthdates in the following order: month, day, year. Example: June 12, 1947 would be |0|6|1|2|4|7|.

12A-F SEX: The respondent should enter their and their family members' sex in the appropriate boxes: female = 1; male = 2.

13. OTHER HEALTH INSURANCE: The respondent should indicate whether or not they have any other health insurance by checking: yes = 1; no = 2. If yes, respondent should enter name of company.

14. POLICY NUMBER: The respondent should enter the policy number of their "other health insurance", IF AVAILABLE.

15. PERSONS COVERED: The respondent should enter the names of all family members covered by their "other health insurance".

16. CHOICE NOT SAME: The respondent should write a short explanation of why they chose PHPs for some family members and regular Medi-Cal for others, IF APPROPRIATE. The respondent should be encouraged to use their own words and SHOULD NOT BE COACHED.

17. PLAN CHOICE: The respondent should indicate the plan of their choice. IF APPROPRIATE.

18. METHOD OF CONTACT: The respondent should indicate how they would like the plan to contact them: home visit = 1; phone = 2; IF APPROPRIATE.

FOR ITEMS 19-26, THE RESPONDENT SHOULD COMPLETE ITEMS 19-22 ONLY IF ENROLLING IN A PHP AND ITEMS 23-26 ONLY IF CHOOSING REGULAR MEDI-CAL CARD.

19. MAIN REASON ENROLLING: The respondent should indicate the main reason they enrolled in a PHP. They should be encouraged to use their own words and SHOULD NOT BE COACHED.

20. ALL SERVICES BY THE PLAN: The respondent should indicate whether or not it was important to them that all of their medical services are provided by the plan they chose: yes = 1; no = 2.

21. OTHER IMPORTANT FEATURES: The respondent should indicate what other features of the plan were important in their decision to enroll. The respondent should be encouraged to use their own words and SHOULD NOT BE COACHED.

22. WHAT PHPs SHOULD DO: The respondent should indicate what they think are the most important things PHPs should do for them. The respondent should be encouraged to use his/her own words and SHOULD NOT BE COACHED.

23. MAIN REASON REGULAR MEDI-CAL: The respondent should indicate the main reason why they decided to stay/choose regular Medi-Cal. The respondent should be encouraged to use his/her own words and SHOULD NOT BE COACHED.

24. CHOOSE OWN DOCTOR: The respondent should indicate whether or not it was important to them to choose their own doctor when making their decision: yes = 1; no = 2.

25. OTHER IMPORTANT FEATURES: The respondent should indicate what other features of regular Medi-Cal were important in their dicision to get a sticker card. The respondent should be encouraged to use his/her own words and SHOULD NOT BE COACHED.

26. WHAT MEDI-CAL SHOULD DO: The respondent should indicate what they think are the most important things Medi-Cal should do for them. The respondent should be encouraged to use his/her own words and SHOULD NOT BE COACHED.

27-36. TRUE/FALSE: The respondent should indicate whether they think each statement is true or false by circling T or F as appropriate. The respondent should be encouraged to answer the questions to the best of their ability but should also be advised that they will not be penalized in any way for not knowing the proper answers. The respondent SHOULD NOT BE COACHED.

37-42. MULTIPLE CHOICE: The respondent should indicate the correct answer to each question by circling the appropriate letter. The respondent should be encouraged to answer the questions to the best of their ability but should also be advised that they will not be penalized in any way for not knowing the proper answers. The respondent SHOULD NOT BE COACHED.

Appendix J: Phone Follow-Up Information Form (PFIF)

PHONE/FOLLOW-UP INFORMATION FORM (PFIF)
VERIFICATION INFORMATION FORM (VIF)
COMBINED VERSION DRAFT #1

(To be used to collect demographic, choice factor, comprehension, and verification data)

INSTRUCTIONS TO THE INTERVIEWER: Fill in as much information as possible before the contact. When using the probe/comment response, circle the appropriate category and write in phrase/question. Make sure that the proper sections are completed for each individual.

MEDI-Cal Number [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ] PHONE [ ][ ][ ]-[ ][ ][ ]-[ ][ ][ ][ ]

I Completed ☐ Follow-up ☐
II Mailer ☐ Current ☐ In-Office ☐
III Enrolled ☐ Not Enrolled ☐

SECTION I--ALL PERSONS

Hello, is this Mrs/Ms/Mr _____? My name is _____, I am with the Department of Health Services.

1. Recently you were contacted: ☐ 1) by mail ☐ 2) at home ☐ 3) at the welfare office ☐ 4) other _____ about joining a pre-paid health plan. You were asked to choose between a PHP and your regular Medi-Cal card. Probe/Comment _____ 1.☐

2. I have down here that you want to:

☐ A) Join a/ _____ PHP with _____ other members of your family. Is this correct?
☐ 1) Yes, continue
☐ 2) No, Probe/Comment _____ 2A.☐

☐ B) Stay with regular Medi-Cal. Is this correct?
☐ 3) Yes, continue
☐ 4) No, Probe/Comment _____ 2B.☐

I would really appreciate it if you would take a few minutes and discuss your decision with me. The Department of Health Services is very interested in improving how health care is provided to you. One important way that we can do that is by getting your opinions.

3. Is this all right with you?

☐ 1) Yes, continue
☐ No, then PROBE: Is there some other time that I could call back that would be more convenient for you?
☐ 2) Yes, take time and date: _____
☐ 3) No, thank respondent for time and say good bye. 3.☐

SECTION II--MAIL RESPONDENTS ONLY

First, Mrs/Ms/Mr _____, I'd like to ask you two questions about the mail packet that you received from the department.

4. What did you think you had to do when you got the mailing?

☐ 1) Enroll in a plan. ☐ 2) Get more information
☐ 3) Send back card to stay on Medi-Cal ☐ 4) Nothing ☐ 5) Other 4.☐

5. Did the mailing help you?

☐ 1) Yes, Comment: _____

☐ 2) No, Comment: _____

☐ 3) Other, Comment: _____ 5. ☐

SECTION III--DEMOGRAPHICS, MAIL, CURRENT RESPONDENTS ONLY

Now, Mrs/Ms/Mr _____, I'd like to ask you some general questions about you and your family.

6. Are you the head of the household?

☐ 1) Yes--ask questions in "YOU" format

☐ 2) No--ask questions in "HEAD OF HOUSEHOLD" format and PROBE: Who is? _____ 6. ☐

7. How old are you/head of household? ☐☐ years 7. ☐

8. What is your/head of household's marital status?

☐ 1) married ☐ 2) divorced ☐ 3) single

☐ 4) separated ☐ 5) widowed ☐ 6) other 8. ☐

9. What was your/head of household's highest grade completed in school? ☐☐ years 9. ☐☐

10. How many children are in the household? ☐☐ children 10. ☐☐

11. How old is the youngest child? ☐☐ years. 11. ☐☐

12. How old is the oldest child? ☐☐ years. 12. ☐☐

13. What language is spoken in your home?

☐ 1) English ☐ 2) Spanish ☐ 3) Other: _____ 13. ☐

14. What would you say is your ethnic background?

☐ 1) Asian ☐ 2) Black ☐ 3) Filipino ☐ 4) Hispanic

☐ 5) Native American ☐ 6) White ☐ 7) Other 14. ☐

SECTION IVA CHOICE FACTORS--HEALTH, ALL PERSONS EXCEPT IN-OFFICE LONG BIF

Next Mrs/Ms/Mr _____, I'd like to ask you about you and your family's health.

15. Do you have a family doctor right now?

☐ 1) Yes

☐ 2) No, then PROBE: Where do you get most of your care right now? _____ 15. ☐

16. How satisfied are you with the care you are receiving from _____? Would you say you are:

☐ 1) Very Satisfied ☐ 2) Satisfied ☐ 3) So-So

☐ 4) Dissatisfied ☐ 5) Very Dissatisfied Comment: _____ 16. ☐

17. How many times have you/head of household seen a doctor in the last year? ☐☐ times — 17. ☐☐

18. How many times have other members of the household seen a doctor in the last year? ☐☐ times — 18. ☐☐

19. How many times have you/head of household been hospitalized in the last year? ☐☐ times — 19. ☐☐

20. How many times have other members of your household been hospitalized in the last year? ☐☐ times — 20. ☐☐

21. Do you or any members of your household need medical care right now?
☐ 1) Yes ☐ 2) No Probe/Comment: _____ — 21. ☐

SECTION IV3 CHOICE FACTORS--DECISION, ALL PERSONS

The next set of questions is about your decision to:
☐ Join a PHP ☐ Stay with regular Medi-Cal

22. Had you ever heard of pre-paid health plans before you were contacted?
☐ 1) Yes ☐ 2) No Probe/Comment: _____ — 22. ☐

23. Have you or anyone in your household ever joined a PHP before?
☐ 1) Yes ☐ 2) No Probe/Comment: _____ — 23. ☐

24. What would you say is the main reason why you decided to:

24A ☐ Join a PHP? _____ — 24A. ☐

24B PROBE: Was it important to you that all of the services were under one roof? ☐ 1) Yes ☐ 2) No _____ — 24B. ☐

24C PROBE: What other reasons were important to you? _____ — 24C. ☐

24D ☐ Stay with regular Medi-Cal? _____ — 24D. ☐

24E PROBE: Was it important to you to choose your own doctor?
☐ 1) Yes ☐ 2) No _____ — 24E. ☐

24F PROBE: What other reasons were important to you? _____ — 24F. ☐

25. What would you say is the most important thing that

25A. ☐ PHPS should do for you? _____ — 25A. ☐

25B. ☐ Regular Medi-Cal should do for you? _____ — 25B. ☐

SECTION V VERIFICATION, ENROLLEES ONLY

Now I'd like to check with you on some things that have or will be happening with your enrollment.

26. Has anyone from the health plan called or come to see you to ask if you have any questions about services?

A. YES, ☐ 1) Phone verification ☐ 2) Home verification
☐ 3) Other _____

B. No ☐ →) — 26. ☐

27. Have you received a plan booklet explaining the services available? 27.☐

☐ 1) Yes ☐ 2) No Comment:

28. Do you understand that joining the plan was completely voluntary and that you don't have to enroll to keep your food stamps or aid? 28.☐

☐ 1) Yes ☐ 2) No Comment:

29. Do you understand that you signed up for a period of one year, but that you can get out for any reason during the first 30 days? 29.☐

☐ 1) Yes ☐ 2) No Comment:

30. Did anyone check to see if you were under a doctor's care? 30.☐

☐ 1) Yes ☐ 2) No Comment:

31. Do you understand that you can't go back to your current doctor unless he or she is on the list? 31.☐

☐ 1) Yes ☐ 2) No Comment:

32. Your enrollment will probably be effective ☐☐☐☐☐, you will know because you won't get your Medi-Cal card and the plan will send you an ID card instead. Until then, do you know how to get health care? ☐ 1) Yes ☐ 2) No Advise: 32.☐

SECTION IV COMPREHENSION QUESTIONS--ALL RESPONDENTS

The last thing I'd like to do is see how well WE presented information about health care to you by asking you some questions about PHPs and regular Medi-Cal. Just answer TRUE if you think the question is true, or False if you think the question is false: Probe/Comment:

33. T F Pre-paid health plans are part of Medi-Cal. 33.☐

34. T F Both regular Medi-Cal and pre-paid Medi-Cal provide basic health care at no cost to you. 34.☐

35. T F People who are eligible for Medi-Cal may choose between regular Medi-Cal and pre-paid Medi-Cal. 35.☐

36. T F Sometimes PHPs offer extra services that regular Medi-Cal doesn't. 36.☐

37. T F People who use regular Medi-Cal have to use the same doctor all the time. 37.☐

38. T F If you are using pre-paid Medi-Cal, you must go to that plan's facilities except in emergencies when you can't get there. 38.☐

39. T F People on Medi-Cal who go to PHPs are guaranteed health care by the plan. 39.☐

40. T F PHPs allow their members to go anywhere they want for health care. 40.☐

41. T F People using regular Medi-Cal must find their own doctors. 41.☐

42. T F It may take up to 45 days to disenroll from a pre-paid health plan. 42.☐

Thank you very much Ms/Mrs _____, for your time and cooperation. You've been very helpful. Just one more thing before I go, I'd like to check and see if I have your correct address. Is it still _____

43. ☐ 1) Yes
☐ 2) No, get correct address. 43. ☐

COMMENTS: _____

44. INTERVIEWER: _____ 44. ☐☐
45. DATE: _____ 45. ☐☐☐
46. TIME: _____ 46. ☐☐☐☐

Appendix K: Coding Instructions for PFIF

Coding Instructions
Phone Follow-Up (Code in Right Hand Column

ITEM	SECTION I - CODE - ALL RESPONDENTS	
1	Method of Contact:	1 = By Mail 2 = At home 3 = Social Service Office 4 = Other
2A	Join a PHP	1 = Yes 2 = NO
2B	Regular Medi-Cal	1 = Yes 2 = No
3	Agreement to Interview	1 = Yes 2 = No 3 = No, refuse interview
	SECTION II - MAIL RESPONDENTS ONLY	
4	What did you think you had to do when you received the mailing	1 = Enroll in plan 2 = Get more information 3 = Send back card 4 = Nothing 5 = Other
5	Did mailing help you?	1 = Yes 2 = No 3 = Other
	SECTION III - MAIL - CURRENT METHOD	
6	Head of Household	1 = Yes 2 = No

7 How old are you?
00 - 99

8 Marital Status
1 = Married
2 = Divorced
3 = Single
4 = Separated
5 = Widowed
6 = Other

9 Highest grade in school?
00 - 99

10 Children in Household?
00 - 99

11 Age of Youngest Child?
00 - 99

12 Age of Oldest Child?
00 - 99

13 Language spoken at home?
1 = English
2 = Spanish
3 = Other

14 Ethnicity
1 = Asian
2 = Black
3 = Filipino
4 = Hispanic
5 = Native American
6 = White
7 = Other

SECTION IV - ALL PERSONS, HEALTH

15 Do you have a family doctor right now?
1 = Yes
2 = No

16 Satisfaction with current care?
1 = very satisfied
2 = satisfied
3 = so-so
4 = dissatisfied
5 = very dissatisfied

17 How many times seen a doctor in last year
00 - 99

18 How may times other members of the household seen doctor in the last year?
00 - 99

19 How many times hospitalized in the last year?
00 - 99

20 How many times household members hospitalized in last year?
00 - 99

21 Need medical care right now?
1 = Yes
2 = No

ITEM	SECTION IVB - CHOICE FACTORS - ALL

22 Heard of pre-paid health plans before?
1 = Yes
2 = No
3 = Don't know

23 Have you or anyone in your household ever joined a PHP before?
1 = Yes
2 = No
3 = Don't know

24 *A Main reason for joining a PHP
0 - 9 (codes to be devised)

B Services under one roof
1 = Yes
2 = No
3 = Other

*C What other reasons were important to you
0 - 9 (codes to be devised)

*D Stay on regular Med-Cal
0 - 9 (codes to be devised)

E Was it important to keep your own doctor?
1 = Yes
2 = No
3 = Other

F What other reasons were important to you?
0 - 9 (codes to be devised)

25 *A What is the most important thing PHP's should do for you?
0 - 9 (codes to be devised)

*B What is the most important thing that regular Medi-Cal should do for you?
0 - 9 (codes to be devised)

ITEM SECTION V - VERIFICATION - ENROLLEES

26 Has anyone from the health plan called or come by to see you to ask if you have questions about services?
1 = Yes, phone
2 = Yes, home (face to face)
3 = Yes, other
4 = No

27 Have you received a plan booklet explaining the services available?
1 = Yes
2 = No
3 = Don't know

28 Do you understand that joining the plan was completely voluntary and that you don't have to enroll to keep your food stamps or aid?
1 = Yes
2 = No
3 = Don't know

29 A. Do you understand that after the first 30 days you can disenroll (get out) for any reason?
1 = Yes
2 = No
3 = Don't know

29 B. Do you understand that after the first 30 days you can disenroll if you are dissatisfied after you use the plan's grievance system?
1 = Yes
2 = No
3 = Don't know

30 Did anyone check to see if you were under a doctor's care?
1 = Yes
2 = No
3 = Don't know

31 Do you understand that after your enrollment begins you can't go back to your current doctor unless he or she is on the list?
1 = Yes
2 = No
3 = Don't know

32 Your enrollment will probably be effective _____, you will know because you won't get your Medi-Cal card and the plan will send you an ID card instead. Until then do you know how to get health care?

1 = Yes
2 = No
3 = Don't Know

SECTION VI - COMPREHENSION QUESTIONS - ALL

33 Pre-paid health plans are part of Medi-Cal?
True = 1
False = 2
Don't know = 3

34 Both regular Medi-Cal and pre-paid Medi-Cal provide basic health care at no cost to you?
True = 1
False = 2
Don't know = 3

35 People who are eligible for Medi-Cal may choose between regular Medi-Cal and pre-paid Medi-Cal?
True = 1
False = 2
Don't know = 3

36 Sometimes PHP's offer extra services that regular Medi-Cal doesn't?
True = 1
False = 2
Don't know = 3

37 People who use regular Medi-Cal have to use the same doctor all the time?
True = 1
False = 2
Don't know = 3

38 If you are using pre-paid Medi-Cal, you must go to that plan's facilities except in emergencies when you can't get there?
True = 1
False = 2
Don't know = 3

39 People on Medi-Cal who go to PHPs are guaranteed health care by the plan?

True = 1
False = 2
Don't know = 3

40 PHPs allow their members to go anywhere they want for health care?

True = 1
False = 2
Don't know = 3

41 People using regular Medi-Cal must find their own doctor?

True = 1
False = 2
Don't know = 3

42 It may take approximately 60 days to disenroll from a pre-paid health plan?

True = 1
False = 2
Don't know = 3

43 Correct address?

1 = Yes
2 = No

44 Interviewer:

01 = Marguerite = MG
02 = Suzanne = SH
03 = Bob
04 = Kathy
05 = Anthony
06 = Tom B.
07 = Jo

45 Date of interview:

Code Julian (000 - 365)

46 Time of day:

(Code actual clock time)

47 Number of tries:

01 - 99

48 Interview time:

Code minutes: 01 - 99

General

- o If blank, leave blank
- o Righ justify single digit is in two or more digit fields.
- o Respondents should be encouraged to answer or guess if need be. Do not settle for the initial "Well, I don't know".

APPENDIX G

Field Experience/Observation of PHP Marketing Practices

SUMMARY: Field Experience/Observation of PHP Marketing Practices

The quality of care provided by a PHP is not a factor in this report, and is not to be impugned by any element of this report. I feel that it is vital to make this disclaimer before I go any further, as much of what is to follow may adversely reflect on the PHPs represented by the enrollers whose activities I observed.

In each instance, the representative was to some extent intimidated by my presence--some more so than others. Some representatives responded very positively to my reassurances and were able to enroll clients, others were unable to relax and may have suffered financial loss because of the effects of the stress.

The overall impression I received was that a person had to be highly motivated, either by monetary compensation and incentives offered by the PHP, or by the need for a job, in order to be successful as a door-to-door enroller. Many of the reps had a great deal of experience in sales, although none intended to stay in sales forever.

The success of a representative depends on the willingness to "sell the product" including the "hard sell" approach, facing open hostility, and pounding the pavement for long hours, sometimes without a break, rest-stop, or meal all day. The sheer "guts" required to keep on knocking on doors day after day, week in and week out in the worst parts of town is vital to the success of a representative, but it cannot be compensated for by money, because of the toll such work takes on the body, mind, and spirit of the person.

The success of this marketing method, is, in turn, dependent upon the character, personality, and ethics of the representative. This could work very much to the disadvantage of the PHP, because of the low salary (even including the widely fluctuating commission) and the lack of job-security (quota-systems preclude security: a bad month may be your last month), and the high turnover rate. These factors tend to make it highly unlikely that the PHPs will be able to attract highly ethical employees.

The attitude of the representative toward the work was heavily influenced by the rate of pay. Some had worked for other PHPs and the stated reason for leaving was for better pay and/or incentives. None of the representaties admitted that it might have been a question of not meeting the plan's quota. Their attitude about the plan they worked for was apparently of very little concern; they usually expressed the feeling that one plan is much like another, as one product is much like any other.

The widest variation in attitudes was toward the clients/consumers. Some representatives maintained a neutral stance, and made no comment

either about the clients or the welfare system. Other reps were very vocal in their dislike for the clients (one representative would not enter their homes for fear of carrying away "bugs") and for the clients' dependence upon welfare (some of the reps stated that they would "even stay in sales forever" rather than "go on welfare"). I observed only one rep who was actively involved in caring for the clients (the rep had taken in a destitute young couple, had fed them, and given them money, and provided them with an address in order to secure emergency aid while establishing residency).

The techniques used to make the presentation ranged from the "hard sell" with rapid-fire questions and repeated demands for responses, to the "glad hand" with its smiles and dialectal catch-phrases and conversational chit-chat about babies, the weather, astrological signs, and national sports.

Some reps preferred to "work the food stamp office," but for a variety of reasons. The most obvious was the preselection of eligible clients. The desire for this preselection, however, varied from a desire to avoid facing possibly hostile clients to a desire to have a "sure thing." The techniques employed at the food stamp office were among the most blatantly unethical, and personally embarrassing that I observed. One rep even asked me to interview a Spanish-speaking client in order to get the information for a later home visit. Some of the reps followed a client from the food stamp office to the bus stop or to their car (one actually ran after them). In each instance the rep continued to talk to the client right up to the time they drove away; in some instances requiring rudeness on the part of the client in order to get away.

My observation of some of the reps doing follow-ups of leads obtained from lists of fee-for-service users of the plan's facilities or from other undefined sources found a very high (50 percent or more) "no show" rate. Even when a rep called in advance to confirm the appointment, less than half responded to the knock on the door. This lack of response was also seen in the number of doors knocked on without any response (as many as 80 percent did not answer), and the large number of immediate "I don't want any" responses when the door was opened (about half of those who answered). In my opinion, this constitutes a tremendous waste of time, energy, and money, and serves to reinforce the active hostility of the general public toward the health plans which in turn require a "hard sell" approach in order to "sell" enough to make the quota. It's a vicious cycle endlessly repeated.

The only observation of presentations made either in the welfare office or the plan's membership services office were extremely limited by the rather widely-spaced appointments. Even in these environments the "no show" rate was 50 percent. The number of enrollments per contact was apparently very high, but no mention was made of retention rate. The attitude of the representatives in these locations was more relaxed and more positive. They used fewer pressure tactics and allowed the clients

more time to review the printed materials and to ask questions. The only complaint the reps in this setting had was the lack of commission-incentives for the large number of enrollments per month.

Conclusion

Random door-to-door canvassing of poverty areas is only as effective as the salesmanship of an individual representative. It is unorganized, inefficient, expensive, and does not relate in a positive way, if at all, to the quality of services provided by a particular plan, nor to the values of the concept of prepaid health plans in general.

-- Joanne Coogan
August 31, 1979

APPENDIX H

Proposal for Implementation of Dual Choice Method

DEPARTMENT OF HEALTH SERVICES
1980–81 FISCAL YEAR
BUDGET CHANGE PROPOSAL DETAIL

DIVISION: Medical Care Standards SECTION: Eligibility Standards

BRANCH: Eligibility REPORTING UNIT CODE: 805 – 320

SHORT TITLE: Eligibility/PHP Unit

Personal Services	Person Years	Salary Range	C.Y. Amount	B.Y. Amount
Staff Services Manager I	1.0	$1,958-2,362		$23,496
Associate Governmental Program Analyst	4.0	$1,782-2,149		$85,536
Office Assistant II	1.0	$ 804-1,048		$ 9,648

Subtotal, Salaries and Wages		$118,680
– Salary Savings (5%)		5,934
Net Total, Salaries and Wages		$112,746
+ Staff Benefits (29.1%)		32,809
Total Personal Services		$145,555
Operating Expenses*		
General Expense		$ 7,440
Communications		
Rent		7,440
Travel		13,375
Printing		50,000
Equipment		7,775
Other (specify)		
Total Operating Expenses		$ 86,030
EDP (Detail attached)		
Administrative Overhead (38.3%)		$ 55,748
Total Expenditures		$141,778
Source of Funds		
General Fund		$ 76,560
Federal Funds		$ 65,218
Other (specify)		

*See other side for standardized costs

HAS 1109 (8/79)

FINANCE LETTER PROPOSAL
Medi-Cal Dual Choice Unit

Summary/Recommendation

Establish a new unit within Medi-Cal Eligibility Branch to implement the PHRED demonstrated marketing method in the county welfare offices in which county staff would offer clients a choice in receiving health care services at the time of eligibility determination and redetermination. The unit would be responsible for all Departmental liaison with the AFDC cash grant staff and the dual choice process in the counties served by PHPs.

Problem

AB 1693, 1978, strengthened by AB 1128 and SB 702, in 1979, mandates the Department to provide information to Medi-Cal beneficiaries about Medi-Cal delivery system alternatives, in areas in which alternatives exist, during the eligibility determination process in the county welfare offices. Additionally, the law authorizes the Director to require the counties "to inquire as to whether the beneficiary wishes to choose a particular alternative." Other sections of the law abolish the prevalent practice of door-to-door solicitation of enrollments for Medi-Cal prepaid health plans as of 31 December 1979, with a one-year waiver possible on a plan-by-plan finding of fact basis. (One additional year, only, of waiver is possible, effectively ending this problem-ridden marketing method by 31 December 1981.) (Legal cites: Welfare and Institutions Code, Section 14016.5, 14404, 14405, 14408(d).)

Background

The Department, with the understanding of the Legislature and the health plans, has delayed implementation of these mandates, pending the results of the marketing and enrollment demonstrations of the Prepaid Health Research, Evaluation, and Demonstration (PHRED) Project, which was funded to develop the methods by which the Department will replace door-to-door solicitation. Final evaluation of the demonstration results will not be available until mid-summer; however, the Project's on-going analyses of data from its seven demonstration sites in welfare offices in Northern and Southern California show a consistent HMO-PHP choice by approximately 18 percent of those presented with information about a fee-for-service card and enrolling in a Medi-Cal PHP. The 18 percent Medi-Cal PHP choice closely parallels the 20 percent of California's total population presently enrolled in HMOs or PHPs. It indicates the program's size, currently static with about 120,000 beneficiaries enrolled, would expand if the information and choice were offered universally in all welfare offices in PHP service areas.

Cost data from the Project indicate the Department could save program dollars in two ways by implementing this dual choice for Medi-Cal beneficiaries at eligibility. The savings would come from lower individual enrollment costs ($11.61 in welfare offices) over the very expensive door-to-door process in which every new enrollment costs a conservatively estimated $40. This cost is currently paid by the health plans from the administrative portion of their capitation rates. If it were no longer an expense, the Department could either decrease the capitation rate by the complete amount saved or direct the

plans to use a portion of the savings to increase benefits and thus attract more members. Attracting more members would increase the second area of savings, the $4.87 per enrollee, per month, the Department saves in estimated lower costs to take care of AFDC beneficiaries in prepaid health plans. Even without increased benefits, however, PHRED projects an increase in enrollments over the number currently being enrolled by the plans when the welfare office methods are totally in place.

Alternatives

1. Do nothing, and maintain the status quo.

2. Have PHP marketing representatives come into the welfare offices to provide information about their plans and enroll those interested.

3. Implement the law on a minimal basis and distribute written information through printed folders.

4. Have State staff make presentations of information and request choices during eligibility determination and redetermination in the county offices.

5. Have specially trained county staff (one person per office) make presentations of information and request choices during eligibility and redetermination.

Discussion of Alternatives

1. Because of the legal limits on door-to-door solicitation it is not possible to maintain the status quo for long. Data from the Project indicate the dual choice in the welfare offices is the only viable alternative with which the Department can replace solicitation and maintain plan viability and program growth. The process cannot be implemented overnight in the more than 70 welfare offices in the State currently in areas served by PHPs. It will take some time to phase-in fully. Thus, to meet the time constraints of the law ending door-to-door solicitation, the Department must begin now.

2. Although having the PHPs do the marketing might appear simpler and perhaps more productive of enrollments because of the enthusiasm expected of sales representatives from the plans, there are several difficulties which are likely to prove counter productive: (1) Because of the ever-present danger of misrepresentation, actual or merely alleged, it would be necessary to have monitors (State or county personnel) in each site to be sure that presentations of information and choice were given objectively. Thus, both the plans and the State would be bearing costs for the marketing. (2) The hostility of county welfare department workers toward the PHP program, a legacy of past scandals and client problems, has been documented again and again, most recently by PHRED. If this alternative were implemented, the workers would not accept the choice presentation of the PHP representative as objective and would likely advise their clients against joining.

3. PHRED's data on the results of the use of printed materials to present the choice indicate an average of about four percent choice for HMOs/PHPs across the seven sites, with a range of less than one percent to five percent. Even the higher number would not be enough to guarantee program viability, and would definitely not afford growth opportunity. Thus, while there might be some enrollment resulting, this inexpensive method, unfortunately, could not replace door-to-door solicitation.

4. Using specially trained and dedicated (in the workload sense) county workers or using State field representatives to present the choices in the welfare offices would cost virtually the same amount. While the State staffing would afford maximum control to the Department in this rather sensitive area, it would cause more disruption to the existing eligibility determination process. Presentations could not be made as frequently by State workers as they would be responsible for "circuit-riding", covering several offices. Clients would have to wait for presentations or return to the offices. Further, most welfare offices do not have meeting rooms of sufficient size for a once-a-day presentation.

5. The recommended alternative is discussed below.

Recommendation

The fifth alternative, placement of the dual choice presentation responsibility on specially trained county staff, is recommended as the most feasible and effective method to meet the mandates of the law and to enhance the growth of a cost-containing and cost-saving program. After special training and with monitoring from the new unit, the cash-grant Medi-Cal worker in each office will be able to serve as a resource for all PHP eligibility problems as well as making consistent, objective presentations of the dual choice information. To support the presentation, the State will provide a general information printed folder and choice form; the plans in the area will supply copies of their marketing materials for distribution. All new eligibiles/applicants will be directed to the dual choice presentations, which may be made to large or small groups as individual office facilities and procedures dictate. Redetermination applicants will either attend the group presentation or be given the written materials and choice forms only.

Workload

There are currently 72 welfare offices co-located with current PHP service areas. With full implementation, presentations could be made to 435,000 applicants representing 1.2 million potential beneficiaries each year. Workload estimates for county staff are attached separately. For staff of the new dual choice unit in the Medi-Cal Eligibility Branch workload is summarized below:

1. Three Associate Government Program Analysts would function as monitors for the counties in which PHPs are located. One would handle Los Angeles County, only, because of the number of health plans and social services offices in that county. The other two would divide up the remaining Southern California and Northern

California counties between them. These analysts would be responsible for:

a. Negotiating agreements with the counties.

b. Implementing regulations and procedures through the Department of Social Services which has primary responsibility for the AFDC eligibility process.

c. Training county workers and overseeing the implementation of the process in each office affected in the county.

d. Maintenance of a close relationship with area health plans for early notice of changes in health plan services or locations.

e. Periodic verification of a sample of enrollees or fee-for-service care choosers to determine the objectivity, consistency, and thoroughness of the county workers' presentations.

f. Solutions of any cash-grant Medi-Cal eligibility problems that might arise in the offices or the counties, generally.

2. The fourth AGPA would function in-house:

a. Developing model procedures and implementing regulations with the DSS.

b. Working out similar (to the extent possible) agreements with the Social Security Administration for the offering of dual choice information to the SSI/SSP recipients.

c. Developing printed material.

d. Developing and maintaining a management information system.

3. In addition to supervision of the above tasks and workers, the Staff Services Manager I would provide liaison with the PHP Branch and with the Office of Alternative Health Systems concerning the development of new contracts with PHPs and those pilot projects which involve enrollment.

4. The Office Assistant will provide usual secretarial services and travel arrangements and will maintain the inventory of printed materials, supplying each office as required.

Savings

The cost of establishing a monitoring unit within the Department would be approximately $140,000. County administrative costs are estimated at $1,608,000. PHRED Project demonstrations to date show that dual choice presentations in the 72 welfare offices within PHP areas can generate sufficient HMO enrollments to replace door-to-door solicitation and increase

HMO enrollment by approximately 7 percent per month. Reduction of capitation rates and shift of fee-for-service costs to HMO savings should result in a $3.3 million savings per annum over and above the $1.7 million cost of the unit and the additional county staff. (See attached implementation cost and enrollment estimates.)

Impact

For each presentation a choice would be made for 2.75 family members. Assuming an 18 percent choice for an HMO/PHP, 150,727 enrollments would result. Although these new enrollments will generate a savings by shifting their health care from the fee-for-service sector to the prepayment mode, the major savings which would materialize would result from the reduction of the marketing costs currently paid by the Department to prepaid health plans. This payment is difficult to distinguish because it is lumped into the administrative component of the capitation rate, but we can estimate the amount by studying the plan-reported costs for new enrollments. (See attached fiscal display.)

The establishment of a core unit of State employees to monitor the PHP/HMO dual presentations by county workers will effectively:

1. Increase enrollments in prepaid health plans.

2. Open a communication channel with counties, thereby alleviating many of the misperceptions surrounding the PHP program and aiding in the early detection of problems.

3. Generate a savings of approximately $3,300,000 per annum (see attached fiscal display).

4. Replace the narrowly focused and unmonitorable door-to-door solicitation method curently employed by most prepaid health plans.

5. Meet the legal mandates currently in statute.

Prepaid health plan contractors have expressed support for eliminating door-to-door solicitation as soon as possible. Counties are reluctant to assume additional duties for each eligibility worker but would accept State staff, or State-funded county workers, offering the dual choice. Consumer groups have largely been indifferent to the PHRED demonstrations but are generally supportive of the dual choice concept.

Depiction of County Costs

Assumptions

1. There will be four daily presentations per office about one-half hour plus two hours for presentation preparation, forms inventory and ordering, and processing paperwork to register clients in the appropriate system. (Because Alameda County has a single group meeting per day, the three welfare offices in that county will require only two hours per day.)

2. There are 69 welfare offices co-located with PHP service areas plus the three welfare offices in Alameda County.

3. Medi-Cal worker costs plus administrative overhead are averaged statewide for those counties in which PHPs are located. The cost is $21.61 per hour. Source is the FY 78/79 Cumulative WACC Report.

Computations

2 hours per day x 22 days per month x 12 months =	528 hrs
4 hours per day x 22 days per month x 12 months =	1,056 hrs
528 hours x 3 welfare offices (Alameda) =	1,584 hrs
1,056 hours x 69 welfare offices =	72,864 hrs
(72,864 + 1,584 hours) x $21.61 per hour =	$1,608,821

Total Costs

Eligibility/PHP Unit	$ 141,778
County Staff	1,608,821
Total Costs	$1,750,599

FULL YEAR IMPLEMENTATION
Fiscal Display

AFDC Eligibles 1/	900,000
AFDC Applications Per Annum	1,200,000
AFDC Cases (Intake + Redetermination)	435,000
Potential HMO Choices (at 18%)	78,300
Potential Line Items (x 2.75)	215,325
Potential Enrollment (70%) 2/	150,727
Potential Enrollments	150,727
Current Disenrollment Rate (4% per month)	56,640
Net Enrollment Increase	94,087
Average Monthly Enrollment Increase	7,840

Savings

FFS Savings of New Enrollments 3/ ($4.87 per head per month)	$ 458,170
Marketing Cost Savings 4/	
Capitation Rate Component for Marketing: $39.22 ÷ 12 mos. = $3.27	
PHP AFDC Population: 109,250	
Add New Enrollments: 109,250 + 7,840 = 117,090 monthly average enrollment	
117,090 x $3.27 x 12 = $4,594,612 annual capitation rate reduction	
Marketing Cost Savings: $4,594,612 - $1,750,599 (BCP costs)	$2,844,013
Total Estimated Savings	$3,302,183

1/ PHP counties only. CHS 10/01/79.

2/ Potential enrollment is indicated at 70 percent due primarily to determination of ineligibility subsequent to the presentation of the dual choice.

3/ FFS savings for new enrollments is based on capitation rates as health care costs at 14 percent below FFS costs for AFDC population.

4/ Marketing cost savings represent real dollar savings to PHPs and the Department through rate reduction/redirection. The savings is estimated on data supplied via current method evaluation by the PHRED Project supported by self-reported PHP costs of $39.22 per enrollment. (In other contexts, plans have reported costs of $45-$50 per person enrolled.)

This bill would revise that provision to prohibit such solicitation after December 31, 1979, except as authorized by the department, on a plan-by-plan basis, as specified.

The people of the State of California do enact as follows:

SECTION 1. Section 14016.5 of the Welfare and Institutions Code is amended to read:

14016.5. The director shall require that, at the time of determining or redetermining the eligibility of a Medi-Cal beneficiary who resides in an area served by a prepaid health plan and is eligible to enroll in such a plan, the county shall inform the Medi-Cal beneficiary of options available to him regarding methods of receiving Medi-Cal benefits and shall inquire whether the beneficiary wishes to choose any particular method.

SEC. 2. Section 14300 of the Welfare and Institutions Code is amended to read:

14300. The department shall conduct a public hearing at least 30 days prior to the execution of an initial contract with a prepaid health plan and within 120 days prior to the renewal of a prepaid health plan contract to hear and receive evidence on the ability of the prepaid health plan to fulfill its responsibilities under the contract. The hearing shall be conducted in the county within which the prepaid health plan is located, or in the case of a prepaid health plan situated in more than one county, in the county where the largest number of Medi-Cal beneficiaries are enrolled in the plan.

Notice of the time, date, and place of the hearing shall be mailed to the following:

(a) The prepaid health plan applying for the contract or contract renewal.

(b) Medi-Cal beneficiaries enrolled in the prepaid health plan subject to the hearing.

(c) Any interested party who requests notification of public hearings conducted pursuant to this section.

The department shall present evidence and make a finding of fact as to the ability of the prepaid health plan to comply with its previous and proposed contract obligations.

No contract shall be renewed unless the department makes a finding based upon the evidence presented at the public hearing, including evidence presented by the department, that the prepaid health plan has complied substantially with its contract obligations.

SEC. 3. Section 14301 of the Welfare and Institutions Code is amended to read:

14301. (a) The department shall determine, by actuarial methods, prospective per capita rates of payment for services provided under this chapter for Medi-Cal beneficiaries enrolled in a prepaid health plan. The rates of payment shall be determined annually, shall be effective no later than the first day of July each

subdivision (a) to reflect such change. During such period of time as is required to redetermine the per capita rates, payment to a prepaid health plan of the per capita rates in effect at the time such change occurred shall be considered interim payments and shall be subject to increase or decrease, as the case may be, effective as of the date on which such change is effective.

(d) The obligations of a prepaid health plan shall be changed only by contract or contract amendment wherein payment for the changes, whether payment results in an increase or decrease in the prior per capita rates paid to a prepaid health plan, shall be determined in accordance with this section and paid to affected prepaid health plans.

(e) Nothing contained in this section shall be construed as removing from a prepaid health plan the risk of beneficial or adverse effects, including inflation, which normally result from contracting to furnish health services.

SEC. 4. Section 14405 of the Welfare and Institutions Code is amended to read:

14405. The director shall make available such information as is necessary to enable Medi-Cal beneficiaries to exercise an informed choice in receiving benefits under this chapter. For this purpose each prepaid health plan shall provide marketing material to the director for distribution to all prospective enrollees in the plan's service area. Such marketing material shall include the following:

(a) A description of all services and benefits provided by the prepaid health plan.

(b) The location of facilities where benefits and services are provided.

(c) The hours and days when services are available at each of the facilities.

(d) The names of and addresses where each primary care physician, dentist, optometrist, or psychologist provides health services to enrollees of the prepaid health plan.

(e) The names and addresses of each hospital which has agreed to provide health services to the enrollees.

(f) Names and addresses of each pharmacy providing pharmaceutical services to the enrollees.

(g) Transportation arrangements, both routine and emergency, offered by the prepaid health plan.

(h) Any other information as the department may require.

SEC. 5. Section 14408 of the Welfare and Institutions Code is amended to read:

14408. (a) Notwithstanding the provisions of Section 14118 and except as otherwise prohibited by law, a prepaid health plan which has entered into a contract with the department pursuant to this chapter may make the benefits known to potential enrollees by methods approved by the department.

(b) No prepaid health plan or marketing organization shall

engage in marketing activities prior to written approval by the department. All marketing activities and procedures shall be approved by the department prior to being used by a prepaid health plan or marketing organization. The department may approve, disapprove, or withdraw approval of any marketing activity or procedure. The department shall require the discontinuance of any marketing activity or procedure for which the department withdraws approval.

The prepaid health plan shall be responsible for all presentations by their official representatives and for their ethical and professional conduct.

(c) All printed or illustrated material prepared by the prepaid health plan for dissemination to enrollees or to prospective enrollees shall be submitted to the department prior to such dissemination. The department shall acknowledge receipt of the printed or illustrated material within five days, and shall approve or disapprove such material for dissemination within 60 days after the date of notification that the material has been received. The department may withdraw approval of such material previously approved and order its dissemination discontinued. Where the department notifies the prepaid health plan of its disapproval or withdrawal of approval, the prepaid health plan shall have the right to meet and confer with the director or his designee and demonstrate the purpose and reasonable basis for the distribution of such material to enrollees and potential enrollees.

(d) On or after January 1, 1980, door-to-door solicitation of Medi-Cal enrollees shall not be permitted except by authorization of the department. Prior to authorizing a continuation of door-to-door solicitation, the department shall make a written finding of fact, for each plan for which the department proposes to permit a continuation of door-to-door solication, that alternative methods of marketing and enrollment are insufficient to guarantee enrollment stability for the prepaid health plan. The authorization to continue door-to-door solicitation shall apply to each plan for which the department has made such a finding of fact and shall continue for a period not to exceed one year, except that the department may extend such authorization an additional year by making a new finding of fact. In permitting door-to-door solicitation of Medi-Cal enrollees, it is the intent of the Legislature that the department shall develop alternative enrollment procedures to maximize enrollment stability and growth in prepaid health plans.

federal Public Health Service Act, and which has more than one million enrollees, of whom less than 10 percent are Medi-Cal enrollees, information required pursuant to this subdivision shall consist of reports required to be made to the Department of Health, Education and Welfare pursuant to Title XIII of the federal Public Health Service Act.

SEC. 4. Section 14311 of the Welfare and Institutions Code is amended to read:

14311. Prepaid health plans, the services they provide and the persons receiving such services shall not be subject to the limitations on services set forth in Section 14133 or 14133.1, or the provisions of subdivision (c), (d), and (e) of Section 14120, or the fifth paragraph of Section 14105.

Nothing in this section or in Article 7 (commencing with Section 14490) of this chapter shall relieve the director of his responsibility to provide the benefits provided for in Section 14132. Where a contract between the department and a prepaid health plan does not require the prepaid health plan to provide a benefit to which a Medi-Cal recipient is otherwise entitled, the recipient shall be entitled to receive such benefit pursuant to Chapter 7 (commencing with Section 14000) of this part.

SEC. 5. Section 14312 of the Welfare and Institutions Code is amended to read:

14312. The director shall adopt all necessary rules and regulations to carry out the provisions of this chapter. In adopting such rules and regulations, the director shall be guided by the needs of eligible persons as well as prevailing practices in the delivery of health care on a prepaid basis. Except where otherwise required by federal law or by this part, the rules and regulations shall be consistent with the requirements of the Knox-Keene Health Care Service Plan Act of 1975.

SEC. 6. Section 14404 of the Welfare and Institutions Code is amended to read:

14404. In order to enable Medi-Cal beneficiaries to fully use the system of their choice, at the time of

determining the eligibility for Medi-Cal of persons who reside in an area served by a prepaid health plan and who are eligible to enroll in such a plan, the director shall make available to such persons information prepared by the department summarizing the benefits and restrictions to beneficiaries enrolled in prepaid health plans as opposed to the fee-for-service system. The department shall prescribe the format for providing the information required pursuant to this section.

SEC. 7. Section 14405 of the Welfare and Institutions Code is amended to read:

14405. The director shall make available such information as is necessary to enable Medi-Cal beneficiaries to exercise an informed choice in receiving benefits under this chapter. For this purpose each prepaid health plan shall provide marketing material to the director for distribution to all prospective enrollees in the plan's service area. Such marketing material shall include the following:

(a) A description of all services and benefits provided by the prepaid health plan.

(b) The location of facilities where benefits and services are provided.

(c) The hours and days when services are available at each of the facilities.

(d) The addresses where primary care physicians, dentists, optometrists, or psychologists provide health services to enrollees of the prepaid health plan.

(e) The names and addresses of each hospital which has agreed to provide health services to the enrollees.

(f) Names and addresses of each pharmacy providing pharmaceutical services to the enrollees.

(g) Transportation arrangements offered by the prepaid health plan.

(h) Any other information as the department may require.

SEC. 8. Section 14406 of the Welfare and Institutions Code is amended to read:

14406. (a) Within seven days after the effective date of enrollment, the prepaid health plan shall provide in

APPENDIX I

Technical Details of Data Collection, Processing, and Analysis

APPENDIX I

This appendix identifies the instruments, formats, code structures, and files that were developed for the marketing demonstration analysis.

The general format for presenting the material for each of the three major methods is:

- Instruments - descriptions
- Process and document flow charts
- Instructional guides and forms cycles
- General specifications
- Coding instructions
- Input descriptions
- Output files - generational data groups

I. Welfare Office Methods

Welfare Office Methods (WO)--Five distinct information-giving medias were tested: brochure, HMO representative, state worker, eligibility worker, and film. Forms used to collect data to evaluate these media include:

- Basic Information Form (BIF)--demographic information on the beneficiary.
- Choice and Presentation Information Form (CAPIF)--beneficiary choice and presentation information.
- Phone Follow-Up Information Form (PFIF)*--demographics, comprehension, and retention information; and attitudes about Medi-Cal and health care.
- Referral Information Form (RIF)--identification and contact document sent to the health plan to request additional information on each person choosing enrollment.

*This instrument was the same for all major methods.

State of California—Health and Welfare Agency

Department of Health Services

BASIC INFORMATION FORM FOR MEDI-CAL BENEFITS

See Reverse For Privacy Information Practice Act Notification

PLEASE PRINT YOUR NAME AND ADDRESS IN THE SPACES BELOW:

								R

1. NAME: _____
   Last First Middle
2. ADDRESS: _____
   Street Number Street or Road City
   _____
   County Zip
3. PHONE NUMBER: _____ _____
   Area Code Number

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOU AND YOUR FAMILY:

4. What is your birthdate? | | | | | | | (Month / Day / Year)

5. What is your sex? . . . . . 1) ☐ Female 2) ☐ Male

6. What is your current marital status? (check one) . . . . . 1) ☐ Married 2) ☐ Divorced 3) ☐ Separated 4) ☐ Widowed 5) ☐ Single 6) ☐ Other _____

7. What language is spoken in your home? (check one) . . . . . 1) ☐ English 2) ☐ Spanish 3) ☐ Other _____

8. What is your ethnic group identity? (check one) . . . . . 1) ☐ Asian 2) ☐ Black 3) ☐ Filipino 4) ☐ Hispanic 5) ☐ Native American 6) ☐ White 7) ☐ Other _____

9. What is the highest grade you completed in school? (circle one)
   0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 more than 16

10. For how many children are you seeking aid? (circle one)
    0 1 2 3 4 5 6 7 8 9 10 11 12 more than 12

11. How old is your oldest child? (circle one, unborn = 0)
    0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 more than 19

12. If you have more than one child, how old is the youngest? (circle one, unborn = 0)
    0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 more than 19

PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUR YOUR HEALTH CARE:

13. Do you have a regular source of health care now? 1) ☐ Yes 2) ☐ No

14. If you or a member of your household is sick, where do you usually go for care? 1) ☐ Private Doctor 2) ☐ County Clinic 3) ☐ County Hospital 4) ☐ Emergency Room 5) ☐ HMO/PHP 6) ☐ Other _____

15. Do you or any of the persons for whom you are seeking aid need medical care now? 1) ☐ Yes 2) ☐ No

16. Have you ever heard of Health Maintenance Organizations (HMOs/PHPs) before? 1) ☐ Yes 2) ☐ Not Sure 3) ☐ No

17. Have you or someone in your family ever belonged to a HMO/PHP before? . . . . 1) ☐ Yes 2) ☐ Not Sure 3) ☐ No

This information is requested by the State of California under DHEW Grant No. 96-P-90299/9-02 in order to determine how best to inform beneficiaries of their Medi-Cal options. Completion of the form is voluntary and there are no consequences for not providing the information. Information will be provided to DHEW and possibly other public agencies. For more information or access to your records, contact John Teeter, Project Director, PHRED Project, 455 Capitol Mall, Suite 250, Sacramento, California 95814, (916) 322-4616.

State of California Health and Welfare Agency

Department of Health Services

CHOICE AND PRESENTATION INFORMATION FORM FOR MEDI-CAL BENEFITS

See Reverse For Privacy Information Practice Act Notification

DIRECTIONS: *Please fill in the following information about your health care decision. REMEMBER, a choice should be made for each member of the family for whom you are applying. If you choose to enroll in a Medi-Cal Health Maintenance Organization (HMO/PHP), check the box labeled HMO.*
If you choose a Medi-Cal monthly sticker card, check the box labeled CARD.

C

TO THE STATE DEPARTMENT OF HEALTH SERVICES: I have made a choice between receiving a Medi-Cal monthly sticker card and enrolling in a Medi-Cal Health Maintenance Organization (HMO/PHP). If I (we) are eligible for Medi-Cal, I wish to receive health care benefits for myself and the family members for whom I am authorized to sign as I have indicated in the box below:

1. NAME (Please Print) Last First Middle	2. Relation To You:	3. Decision Check One HMO	3. Decision Check One CARD	4. MEDI-CAL NUMBER	5. BIRTHDATE Mo. Day Year	6. SEX F=Female M=Male
A.	Self					
B.						
C.						
D.						
E.						
F.						
G.						

IF YOU HAVE CHOSEN AN HMO/PHP, CHECK THE BOX BY THE PLAN'S NAME AND TELL US HOW YOU WANT TO BE CONTACTED:

7. ☐ California Medical Group ☐ ComoreCare
☐ Kaiser ☐ Watts Health Plan

8. Contact me . . . . . 1) ☐ At home
2) ☐ By phone

9. Do you have any other Health Insurance? 1) ☐ Yes 2) ☐ No
Company: _____

PLEASE ANSWER THESE QUESTIONS ABOUT YOUR DECISION:

10. Was your decision the same for all members of your family? . . . . . 1) ☐ Yes 2) ☐ No

If you marked no, why was it different for some members?

_____

11. In making your decision, did you think health care in an HMO/PHP would be . . . .
Better than what you receive now . . . . . 1) ☐
About the same as you receive now . . . . . 2) ☐
Not as good as you receive now . . . . . 3) ☐

PRINT YOUR NAME AND ADDRESS BELOW:

Last First Middle _____ Street Number Street/Road City

Sign Name _____ Date _____ County Zip Phone Number

COUNTY/PROJECT USE ONLY BELOW THIS LINE

1. Office (Site Location):
1) ☐ Pittsburg 2) ☐ Richmond
3) ☐ Oakland 4) ☐ Sacramento Co.
5) ☐ East Valley 6) ☐ Florence
7) ☐ Orange 8) ☐

2A. Type of Case:
1) ☐ Intake 2) ☐ Re-evaluation
3) ☐ Aid Code Change 4) ☐ Other

2B. Family Case Number: _____

3. Has client received aid in the last 6 months?
1) ☐ Yes 2) ☐ No

4A. Was printed material received by client?
1) ☐ In Advance 2) ☐ Day of Presentation

4B. Did client report reading the material?
1) ☐ Yes 2) ☐ No

5. Did the client require a translator to understand the written or oral presentations?
1) ☐ Yes 2) ☐ No

6. Date of Presentation: . ___ ___ ___ ___
Mo. Day Year

7. Presentation Setting:
1) ☐ Individual Presentation
2) ☐ Group 3) ☐ Couple 4) ☐ Other

8. Type of Presentation:
1) ☐ Printed Material 2) ☐ EW
3) ☐ HMO Rep 4) ☐ AV (Film)
5) ☐ State Worker 6) ☐ None
If none, explain: _____

ITEMS 9–13, COUNTY, STATE, HMO REP PRESENTATIONS ONLY:

9. Presentation Started _____ : _____ am pm

10. Presentation Ended _____ : _____ am pm

11. Total Presentation Time (In Min.) . . . . . ___ ___ ___

12. Total County EW Time (In Min.) . . . . . ___ ___ ___

13. Total County Clerical Time . . . . . ___ ___ ___

14. Presentation made by: _____

MC 726D (4/79)

REFERRAL INFORMATION FORM (RIF)

1. Referral Number:

2. Referral's Name: (Last, First, Middle)

3. Referral's Medi-Cal Number:

4A. Referral's Address (House Number, Street or Road)

(City) (County)

4B. Zip

5. Referral's Phone Number:

6. Date Sent to Plan:

7. Date RIF returned to PHRED:

Name of Plan

To Plan: The above person has indicated that he/she wishes to enroll after receiving a presentation and/or information in the local Social Services Office.

1-5

8. Please contact this person within: (Days)

9. And return this form to PHRED by: Month Day Year

DESCRIBE THE FIRST CONTACT:

10. Date: (Month, Day, Year)

11. Method of Contact:
1) ☐ Phone 2) ☐ Mail
3) ☐ Home 4) ☐ Walk-in

12. Results of first contact:
1) ☐ Verified Enrollee 2) ☐ Enrolled Other Plan
3) ☐ No Contact 4) ☐ Decision Pending
5) ☐ Stay on Regular Medi-Cal 6) ☐ Other:

13. How many persons enrolled? (Enter number)

14. Does this represent the referral's total family?
1) ☐ Yes 2) ☐ No

15. How many not enrolled?

16. Explain nonenrolling family members (if any)

17. How many attempts were made before the individual was contacted? (Enter number)

IF MORE THAN ONE CONTACT, DESCRIBE THE LAST:

18. Date: (Month, Day, Year)

19. Method of Contact:
1) ☐ Phone 2) ☐ Mail
3) ☐ Home 4) ☐ Walk-In

20. Results of Last Contact:
1) ☐ Verified Enrollee 2) ☐ Enrolled Other Plan
3) ☐ No Contact 4) ☐ Decision Pending
5) ☐ Stay on Regular Medi-Cal 6) ☐ Other:

F

PHONE FOLLOW–UP INFORMATION FORM (PFIF)

(To be used to collect demographic, choice factor, comprehension, and verification data)

I
Completed ☐
Follow-Up ☐
II
Mailer ☐
Current ☐
In-Office ☐
III
Enrolled ☐
Not Enrolled ☐

INSTRUCTIONS TO THE INTERVIEWER: Fill in as much information as possible before the contact. When using the probe/comment response, circle the appropriate category and write in phrase/question. Make sure that the proper sections are completed for each individual.

Medi-Cal Number _____ Phone ____-____-____

SECTION I – ALL PERSONS

Hello, is this Mrs. / Ms. / Mr. _____? My name is _____, I am with the Department of Health Services.

1. Recently you were contacted: ☐ 1) by mail ☐ 2) at home ☐ 3) at the Social Service office ☐ 4) Other _____ about joining a pre-paid health plan. You were asked to choose between a PHP and your regular Medi-Cal card. *Probe/Comment* _____ 1. _____

2. I have down here that you want to:
   ☐ A) Join a/ _____ PHP with _____ Other members of your family. Is this correct?
   ☐ 1) Yes, continue
   ☐ 2) No, *Probe/Comment* _____ 2A. _____

   ☐ B) Stay with regular Medi-Cal. Is this correct?
   ☐ 3) Yes, continue
   ☐ 4) No, *Probe/Comment* _____ 2B. _____

I would really appreciate it if you would take a few minutes and discuss your decision with me. The Department of Health Services is very interested in improving how health care is provided to you. One important way that we can do that is by getting your opinions.

3. Is this all right with you?
   ☐ 1) Yes, continue
   ☐ No, then *Probe: Is there some other time that I could call back that would be more convenient for you?*
   ☐ 2) Yes, take time and date: _____
   ☐ 3) No, thank respondent for time and say good-bye. 3. _____

SECTION II – MAIL RESPONDENTS ONLY

First, Mrs. / Ms. / Mr. _____, I'd like to ask you two questions about the mail packet that you received from the department.

4. What did you think you had to do when you got the mailing?
   ☐ 1) Enroll in a plan. ☐ 2) Get more information
   ☐ 3) Send back card to stay on Medi-Cal ☐ 4) Nothing ☐ 5) Other 4. _____

   Did the mailing help you?
   ☐ 1) Yes, *Comment:* _____
   ☐ 2) No, *Comment:* _____
   ☐ 3) Other, *Comment:* _____ 5. _____

SECTION III DEMOGRAPHICS – MAIL, CURRENT METHOD ONLY

Now, Mrs. / Ms. / Mr. _____, I'd like to ask you some general questions about you and your family.

6. Are you the head of the household?
   ☐ 1) Yes – ask questions in "YOU" format
   ☐ 2) No – ask questions in "HEAD OF HOUSEHOLD" format and
   PROBE: Who is? _____ 6. _____

7. How old are you/head of household? _____ years 7. _____

8. What is your/head of household's marital status?
   ☐ 1) married ☐ 2) divorced ☐ 3) single ☐ 4) separated ☐ 5) widowed ☐ 6) other 8. _____

9. What was your/head of household's highest grade completed in school? _____ years 9. |__|__|

10. How many children are in the household? |__|__| children 10. |__|__|

11. How old is the youngest child? |__|__| years 11. |__|__|

12. How old is the oldest child? |__|__| years 12. |__|__|

13. What language is spoken in your home? ☐ 1) English ☐ 2) Spanish ☐ 3) Other: _____ 13. _____

14. What would you say is your ethnic background?
   ☐ 1) Asian ☐ 2) Black ☐ 3) Filipino ☐ 4) Hispanic
   ☐ 5) Native American ☐ 6) White ☐ 7) Other_____ 14. _____

SECTION IV. A CHOICE FACTORS – HEALTH, ALL PERSONS

Next, Mrs. / Ms. / Mr. _____, I'd like to ask you about you and your family's health.

15. Do you have a family doctor right now?
   ☐ 1) Yes
   ☐ 2) No, then *PROBE: Where to you get most of your care right now?* _____ 15. _____

16. How satisfied are you with the care you are receiving from _____ ? Would you say you are:
   ☐ 1) Very Satisfied ☐ 2) Satisfied ☐ 3) So-So ☐ 4) Dissatisfied ☐ 5) Very Dissatisfied
   Comment: _____ 16. _____

17. How many times have you/head of household seen a doctor in the last year? _____ times 17. |__|__|

18. How many times have other members of the household seen a doctor in the last year? _____ times 18. |__|__|

19. How many times have you/head of household been hospitalized in the last year? _____ times 19. |__|__|

20. How many times have other members of your household been hospitalized in the last year? _____ times 20. |__|__|

21. Do you or any members of your household need medical care right now?
   ☐ 1) Yes ☐ 2) No *Probe/Comment:* _____ 21. _____

SECTION IV.B CHOICE FACTORS – DECISION, ALL PERSONS

:t set of questions is about your decision to:
☐ Join a PHP ☐ Stay with regular Medi-Cal

22. Had you ever heard of pre-paid health plans before you were contacted?
☐ 1) Yes ☐ 2) No *Probe/Comment:* _____ 22. _____

23. Have you or anyone in your household ever joined a PHP before?
☐ 1) Yes ☐ 2) No *Probe/Comment:* _____ 23. _____

24. What would you say is the main reason why you decided to: 24.
A ☐ Join a PHP? _____ A _____
B *PROBE: Was it important to you that all of the services were under one roof?*
☐ 1) Yes ☐ 2) No _____ B _____
C *PROBE: What other reasons were important to you?* _____ C _____
D ☐ Stay with regular Medi-Cal? _____ D _____
E *PROBE: Was it important to you to choose your own doctor?*
☐ 1) Yes ☐ 2) No _____ E _____
F *PROBE: What other reasons were important to you?* _____
_____ F _____

25. What would you say is the most important thing that 25.
A ☐ PHPS should do for you? _____ A _____
B ☐ Regular Medi-Cal should do for you? _____ B _____

SECTION V VERIFICATION -- ENROLLEES ONLY

l like to check with you on some things that have or will be happening with your enrollment.

26. Has anyone from the health plan called or come to see you to ask if you have any questions about services?
A. Yes ☐ 1) Phone verification ☐ 2) Home verification ☐ 3) Other _____
B. No ☐ 4) 26. _____

27. Have you received a plan booklet explaining the services available?
☐ 1) Yes ☐ 2) No *Comment:* _____ 27. _____

28. Do you understand that joining the plan was completely voluntary and that you don't have to enroll to keep your food stamps or aid?
☐ 1) Yes ☐ 2) No *Comment:* _____ 28. _____

29A. Do you understand that during the first 30 days of membership you can disenroll (get out) for any reason? 29.
☐ 1) Yes ☐ 2) No *Comment:* _____ A _____

29B. Do you understand that after the first 30 days you can disenroll if you are dissatisfied after you use the plan's grievance system.
☐ 1) Yes ☐ 2) No *Comment:* _____ B _____

30. Did anyone check to see if you were under a doctor's care?
☐ 1) Yes ☐ 2) No *Comment:* _____ 30. _____

31. Do you understand that after your enrollment begins you can't to back to your current doctor unless he or she is on the list?
☐ 1) Yes ☐ 2) No *Comment:* _____ 31. _____

32. Your enrollment will probably be effective _____, you will know because you won't get your Medi-Cal card and the plan will send you an ID card instead. Until then, do you know how to get health care?
☐ 1) Yes ☐ 2) No *Advise:* _____ 32. _____

SECTION VI COMPREHENSION QUESTIONS – ALL RESPONDENTS

The last thing I'd like to do is see how well *WE* presented information about health care to you by asking you some questions about PHPs and regular Medi-Cal. Just answer TRUE if you think the question is true, or FALSE if you think the question is false: *Probe/Comment:* _____

Code 1 = Yes 2 = No

33.	T	F	Pre-paid health plans are part of Medi-Cal.	33. _____
34.	T	F	Both regular Medi-Cal and pre-paid Medi-Cal provide basic health care at no cost to you.	34. _____
35.	T	F	People who are eligible for Medi-Cal may choose between regular Medi-Cal and pre-paid Medi-Cal.	35. _____
36.	T	F	Sometimes PHPs offer extra services that regular Medi-Cal doesn't.	36. _____
37.	T	F	People who use regular Medi-Cal have to use the same doctor all the time.	37. _____
38.	T	F	If you are using pre-paid Medi-Cal, you must go to that plan's facilities except in emergencies when you can't get there.	38. _____
39.	T	F	People on Medi-Cal who go to PHPs are guaranteed health care by the plan.	39. _____
40.	T	F	PHPs allow their members to go anywhere they want for health care.	40. _____
41.	T	F	People using regular Medi-Cal must find their own doctors.	41. _____
42.	T	F	It may take approximately 60 days to disenroll from a pre-paid health plan.	42. _____

Thank you very much Mrs. / Ms. / Mr. _____, for your time and cooperation.

You've been very helpful. Just one more thing before I go, I'd like to check and see if I have your correct address. Is it still _____

_____

43. ☐ 1) Yes
☐ 2) No, get correct address. 43. _____

COMMENTS:

_____

_____

_____

_____

44. INTERVIEWER: _____ 44. |_|_|

45. DATE: _____ 45. |_|_|_|

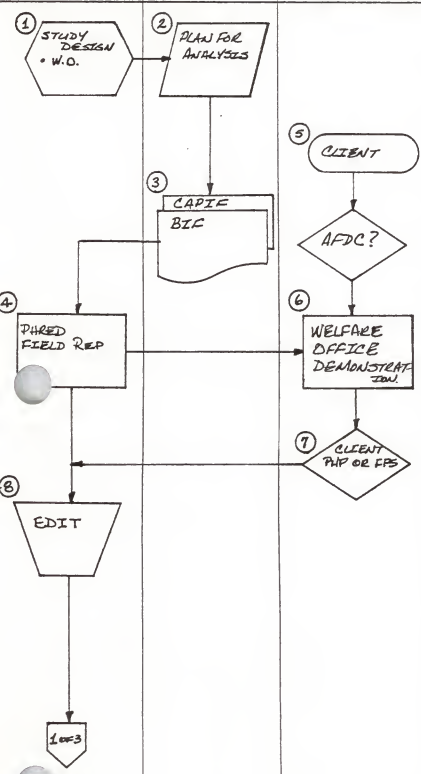
46. TIME: _____ 46. |_|_|_|_|

47. Number of Tries: _____ 47. |_|_| |_|_|

48. Amount of Interview Time: _____ 48. |_|_| |_|_| Minutes

FIGURE 1 - MEMS
WELFARE OFFICE

SEQUENCE/DOCUMENT FLOW/CONTROL/RESPONSIBILITIES



1. Study design & series of questions to be answered & developed.

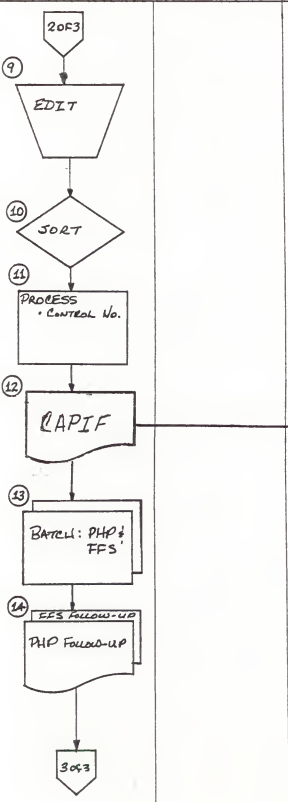
2. Plan for Analysis Developed.
   - output definition
   - process flow
   - data collection

3. Develop instruments.
   - Basic information (BIF)
   - Choice & Presentation Information Form (CAPIF)

4. PHRED field rep. develops
   - W.O. data handling
   - Training of W.O. staff
   - makes presentation
   - ensure data collection is consistent.

5. Client enters W.O eligibility is determined or goes through re-determination process.
   - AFDC new eligibles and redetermination clients participate in office demonstration.

6. Welfare Office demonstrations. AFDC client enters one of five possible conditions:
   - Pamphlet only
   - E.W. presentation & pamphlet.
   - PHRED rep. presentation and pamphlet
   - Plan rep. presentation & pamphlet.
   - A.V. presentation & pamphlet



NARRATIVE

7. Client makes choice at the end of the assigned condition for pre-paid health or fee-for-service.

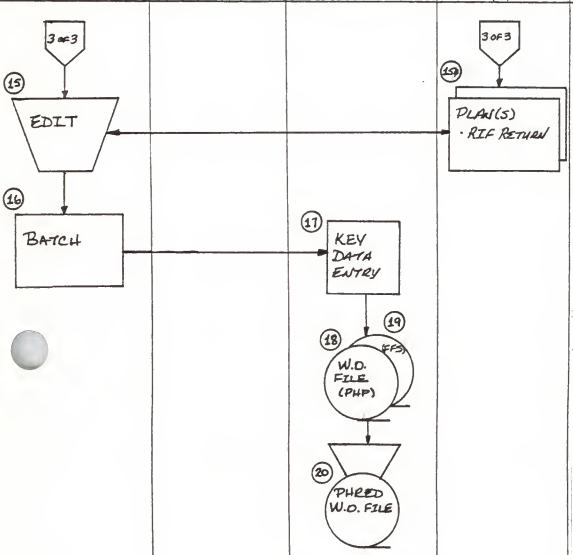
8. PHRED field rep. edits forms to ensure:
   - complete information
   - forms are collected

9. EDIT-Manual-BIF & CAPIF. MEMS clerk checks form for completion & correctly entered:
   - name/address
   - birthdate
   - Medi-Cal No. (one per person)
   - All elements cle[illegible] marked.

   In the event data elements are incomplete MEMS clerk will route to Field Rep. for correction/completion.

10. SORT-Manual-PHP & FFS MEMS clerk sorts the BIF's and CAPIF's of those choosing PHP from those choosing FFS in two piles.

11. PROCESS-Manual
    - stamp control no. on all documents
    - copy of CAPIF
    - fill in top section of RIF



NARRATIVE

12. ROUTE-CAPIF to Plan. Field Rep. generates a RIF and sends/takes it to the Plan. Field Rep. retains listing which is returned to PHRED for document control and batch/sequence assignment.

12A. PLAN-Contact client-RIF

13. BATCH-Prepare PHP and FFS batchs.
    - cover sheet
    - batch log

14. Phone follow-up of all PHP choosers and 20% sample of FFS choosers (See General Specifications)

15. Plan returns RIF, MEMS Clerk edits to insure completeness before

16. Batches of completed documents (RIF, CAPIF, PFIF).
    - RIF submitted when ready.

17. Key data entry

18. Welfare Office File (PHP)

19. Welfare Office File (FFS)

20. Merge to one file

    Welfare Office File (PHP & FFS)

BASIC INFORMATION FORM - INSTRUCTIONAL GUIDE

This document will be completed by each client prior to receiving any information or any presentations.

The following account is an item by item description of the data needed for each question on the Basic Information Form (BIF).

1. NAME
   The respondent should print his/her entire legal name in the spaces provided in this order: last, first, middle.

2. ADDRESS:

   A. Street Number : The respondent should enter the number of his/her house or apartment.

   B. Street or Road: The respondent should enter the name of the street or road.

   C. City : The respondent should enter the name of the city in which he/she lives.

   D. County: The respondent should enter the name of the county in which he/she lives.

   E. Zip : The respondent should enter all five (5) digits of the zip code in which he/she lives.

3. PHONE NUMBER:
   The respondent should enter his/her phone number in the following order - area code (3 digits) - prefix (3 digits) - number (4 digits).

4. BIRTH DATE:
   The respondent should enter his/her birthdate in the following order - month, day, year. Example: June 12, 1947 would be 0|6|1|2|4|7|.

5. SEX:
   The respondent should indicate their sex in the appropriate box - Female - 1; Male - 2.

6. MARITAL STATUS:
   The respondent should indicate his/her current marital status in the appropriate box - Married-1, Divorced-2, Separated-3, Widowed-4, Single-5, and Other-6.

7. LANGUAGE SPOKEN IN HOME:
   The respondent should indicate the primary language spoken in his/her home in the appropriate box - 1-English, 2-Spanish, and 3-Other.

8. ETHNIC GROUP IDENTITY:
   The respondent should indicate his/her acknowledged ethnic group identity (this question should be considered optional) in the appropriate box - 1-Asian, 2-Black, 3-Filipino, 4-Hispanic, 5-Native American, 6-White or 7-Other.

9. HIGHEST GRADE COMPLETED IN SCHOOL:
The respondent should circle their highest grade completed in school - Example: elementary completed (8), high school completed (12), college (BA) completed (16).

10. NUMBER OF CHILDREN IN HOME:
The respondent should circle the number of children living at home and for whom aid is being sought.

11. AGE OF OLDEST CHILD:
The respondent should circle the age of the oldest child at their home for whom she/he is seeking aid in years. Example: if a child is 12 years old - (12) would be circled.

NOTE: IF THERE IS ONLY ONE CHILD IN THE HOME, ENTER AS OLDEST AND LEAVE NO. 12 BLANK. IF CHILD IS UNBORN, CIRCLE (0).

12. AGE OF YOUNGEST CHILD:
The respondent should circle the age of the youngest child at home for whom he/she is seeking aid, in years. Example: if a child is 2 years old, (2) would be circled. If a child is less than 1, circle (1).

13. DO YOU HAVE A REGULAR SOURCE OF MEDICAL CARE:
The respondent should indicate if he/she has a regular source of medical care that he/she goes to when he/she or a member of his/her family has a medical problem. 1-Yes, 1-No.

14. SOURCE OF CARE:
The respondent should indicate the most often used source of health care in the apporpriate box. If the usual source is not listed, the respondent should check "other" and write in the correct source. NOTE: ONLY ONE SOURCE SHOULD BE CHECKED.
1 - Private doctor - someone specific the respondent sees as needed.
2 - County clinic - county outpatient ambulatory medical facility.
3 - County hospital - county inpatient medical facility
4 - Emergency room - county or other emergency facility used as needed.
5 - HMO/PHP - respondent is currently a member of a HMO/PHP.
6 - Other - respondent specify. _____

15. NEED MEDICAL CARE NOW:
The respondent should indicate whether or not he/she or a member of their household, for whom he/she is seeking aid need medical care at the present time. 1-Yes, 2-No.

16. HEARD OF PHPS:
The respondent should indicate whether or not he/she has ever heard of HMOs/prepaid health plans. The "not sure" category should be used when the respondent is uncertain of what a HMO/PHP is, or can not recall.

17. JOINED A HMO:
The respondent should indicate whether or not he/she or a member of the household, for whom they are seeking aid has ever joined a prepaid health plan. The "don't know" category should be used when the respondent is uncertain of what a HMO/PHP is, or can not recall.

CHOICE AND PRESENTATION INFORMATION FORM--INSTRUCTIONAL GUIDE

PART I-CHOICE

This document will be completed by each client after receiving any information or any presentations. The following is an item by item description of the data needed for each question on the CAPIF.

1A-G NAME:
The respondent should enter his/her name in line 1A and the names of family members in 1B through 1G in the following order - last name, first initial, middle initial. IF THE RESPONDENT HAS MORE THAN SIX FAMILY MEMBERS, PLEASE ATTACH ADDITIONAL CAPIF'S WITH ITEMS 1 THROUGH 6 FILLED IN ONLY.

2A-G RELATION TO YOU:
The respondent should enter his/her relationship with the person named. Line 2A has been filled in as "self." Examples of other appropriate responses - son, daughter, niece, etc.

3A-G DECISION:
The respondent should check one box per person as follows:

HMO CHOICE-
The respondent should indicate whether he/she wants to enroll himself/herself and/or his/her family members in an HMO by checking this box as appropriate.

CARD CHOICE-
The respondent should indicate whether he/she wants a Medi-Cal monthly sticker card for himself/herself and/or family members by checking this box as appropriate.

4A-G MEDI-CAL NUMBER:
The respondent should enter his/her and the family members' Medi-Cal numbers as they appear on other offical documents, IF AVAILABLE.

5A-G BIRTHDATE:
The respondent should enter his/her and the family members' birthdates in the following order - month, day, year. Example: June 12, 1947 would be 06-12-47.

6A-G SEX:
The respondent should enter his/her and the family members' sex in the appropriate boxes. Female-1, Male-2.

7 PLAN CHOICE:
The respondent should indicate the plan of his/her choice, IF APPROPRIATE.

8 METHOD OF CONTACT:
The respondent should indicate how he/she would like the plan to contact them. Home-1, Phone-2 and Mail-3.

9. OTHER HEALTH INSURANCE:
The respondent should indicate whether or not they have any other health insurance by checking - Yes-1, No-2, and Don't Know-3. If yes respondent should enter name of company.

10 CHOICE NOT SAME:
The respondent should indicate whether or not his/her decision was the same for all family members. If not, the respondent should write a short explanation.

11 HEALTH CARE IN THE HMO/PHP:
The respondent should indicate what his/her perception of health care in a HMO/PHP is in comparison to his/her current situation. 1-Better than what you receive now, 2-About the same as you receive now, and 3-Not as good as you receive now.

12 IMPORTANCE OF MEDI-CAL STICKER CARD:
The respondent should indicate how important it is to him/her to receive a Medi-Cal monthly sticker card. 1-Very important, 2-Somewhat important or 3-Not important.

UNNUMBERED SECTION:

The respondent should print his/her name and address in the spaces provided.

A - Name: last, first, middle

B - Sign Name: legal signature

C - Date: current date

D - Street Name: current residence

E - Street or Road: current residence

F - City

G - County

H - Zip

I - Phone Number

PART II PRESENTATION

This document is intended for used by County, State or Plan representatives and will be filled out on every client who receives a presentation. If a client should have received a presentation and did not, the form should be completed to the extent possible with an explanation of item no. 11.

1 OFFICE:
(Site Location) The staff members should indicate the location of where the presentation occurred - 1-Pittsburg, 2-Richmond, 3-Oakland, 4-Sacramento County, 5-Los Angeles (a), 6-Los Angeles (b) or 7-Orange County.

2A TYPE OF CASE:
The staff member should indicate the type of case involved, 1-Intake, 2-Re-evaluation, or 3-Aid Code Change or 4-Other.

2B FAMILY CASE NUMBER:
If the client does not have a Medi-Cal number the staff member should indicate the family case number, and follow-up by obtaining the Medi-Cal numbers for all family members who enroll for reporting to the Plan.

3. AID IN LAST SIX MONTHS:
The staff member should indicate (to the best of knowledge) whether or not the client has received aid in the last 6 months. This should also include aid in any other county other than the current one. If the client has received aid in this or another county within the last 6 months, then code -1-Yes, 2-No.

4A PRINTED MATERIAL RECEIVED BY CLIENT:
The staff member should indicate (to the best of his/her knowledge) whether or not the client was given written information, 1-In advance, 2-Day of presentation or 3-None given.

4B CLIENT READ MATERIAL:
The staff member should indicate (to the best of his/her knowledge) whether the client read the material before the presentation, 1-Yes or 2-No.

5 TRANSLATOR NEEDED:
The staff member should indicate whether or not the clients needed a translator to read or understand the written materials and/or presentation, 1-Yes or 2-No.

6 DATE OF PRESENTATION
The staff member should enter the date of the presentation in the following order - month, day, year. Two spaces should be used for each segment. Example: March 1, 1979 would be 03-01-79.

7 PRESENTATION SETTING:
The staff member should indicate the type of presentation setting the client experienced. 1-Individual presentation (materials were given/explained to client on a one-to-one basis), 2-Group presentation (materials were given/explained to client as part of a group process), 3-Couple or 4-Other.

8 TYPE OF PRESENTATION:
The staff member should indicate the type of presentation given to the client. 1-Printed materials only, 2-County eligibility worker, 3-HMO representative, 4-Audio-visual (film), 5-State worker or 6-No presentation. If no presentation was made, please explain why._____

ITEMS 9-13 SHOULD BE FILLED IN ONLY WHEN A CLIENT RECEIVES A PRESENTATION BY COUNTY, STATE OR PHP PERSONNEL. IF CLIENT RECEIVES WRITTEN MATERIAL ONLY, OR A-V, THESE QUESTIONS SHOULD BE LEFT BLANK.

9 PRESENTATION STARTED:
The staff member should enter the clock time which the presentation started. Example: 10:15 in the morning would be |1|0|:|1|5| (AM)/PM.

10 PRESENTATION COMPLETED:
The staff member should enter the clock time at which the presentation ended. Example: 10:30 in the morning would be |1|0|:|3|0| (AM)/PM.

11 TOTAL PRESENTATION TIME:
The staff member should enter the total presentation time in minutes. This should be the difference in minutes of no. 9 from no. 10. Using the example from above - |0|1|5|.

12 TOTAL COUNTY ELIGIBILITY WORKER TIME:
The staff member should enter the total time the eligibility worker spent on the demonstration in minutes. Example: 05 minutes would be |0|0|5|.

13 TOTAL COUNTY CLERICAL TIME:
The staff member should enter the total time the county clerical time spent on the demonstration in minutes. Example: 10 minutes would be |0|1|0|.

14 NAME OF PRESENTER:
The staff member making the presentation should print his/her name.

-Referral Information Form-
Instructional Guide

This document will be completed by PHRED/Plan staff for all persons wishing to enroll from the Social Service Office.

The following account is an item by item description of the data needed for each question on the RIF. Responsibility for each step is indicated in parenthesis at the beginning of the descriptions of each item.

1. REFERRAL NUMBER - (PHRED) PHRED staff will indicate the log number given to each individual. This is a 6 digit code initiated for a client on the BIF. (See General Specifications).

2. REFERRAL NAME - (PHRED/PLAN) PHRED staff will indicate the respondent's name if referring the individual to the Plan; the PLAN will indicate the respondent's name if individual is self-referred. The name should be printed in the following order: last, first, middle with a space skipped between last and first and between first and middle.

3. REFERRAL'S MEDI-CAL NUMBER - (PHRED/PLAN) PHRED staff will indicate the respondent's Medi-Cal number if referring the individual to the Plan; PLAN will indicate the respondent's Medi-Cal number if individual is self-referred.

4A- REFERRAL'S ADDRESS - (PHRED/PLAN) PHRED staff will indicate the
4B. respondent's address if referring the individual to the Plan; PLAN will indicate the respondent's address if individual is self-referred. The address should be filled in as follows: A. the respondent's house number followed by street or road with one space skipped between number and street. If respondent resides in an apartment, apartment number should be entered after street with one space skipped in between, B. the name of the city in which the respondent lives, C. the name of the county in which the respondent lives, D. the respondent's zip code.

5. REFERRAL'S PHONE NUMBER - (PHRED/PLAN) PHRED staff will indicate the respondent's phone number if referring the individual to the Plan; PLAN will indicate the respondent's phone number if individual is self-referred. Phone number should be entered in the followed order: area code (3 digits), prefix (3 digits), number (4 digits).

6. DATE SENT TO PLAN - (PHRED) PHRED staff will indicate the date the RIF was sent to the Plan in the following order: month, day, year. Example: |0|3|2|3|7|9|.

7. DATE RIF RETURNED TO PHRED - (PHRED) PHRED staff should indicate the date the RIF was received by them in the following order: month, day, year.

8. NUMBER OF DAYS TO CONTACT - (PHRED) PHRED staff will indicate the desired number of days the Plan has to contact the respondent.

9. RETURN FORM TO PHRED BY - (PHRED) PHRED staff will indicate the date the RIF should be returned to them by the Plan in the following order: month, day, year.

10. DATE OF FIRST CONTACT - (PLAN) The Plan should indicate the date of first contact with the individual in the following order: month, day, year. Example: April 5, 1979 would be -|0|4|0|5|7|9|.

11. METHOD OF FIRST CONTACT - (PLAN) The Plan should indicate the method of first contact with the individual with: 1=phone call, 2=mailed material, 3=home visit, 4=walk-in (respondent walks into Plan on own).

12. RESULTS OF FIRST CONTACT - (PLAN) The Plan should indicate the results of their first contact with the individual with - 1=verified enrollee, 2=enrolled in another Plan, 3=no contact, 4=decision pending, 5=stay on regular Medi-Cal, and 6=other.

13. NUMBER OF PERSONS ENROLLED - (PLAN) The Plan should indicate the number of persons enrolled as a direct result of this referral. IF NO PERSONS ENROLL MARK|0|0|. In other cases, indicate the exact number - Example - 6 persons would be|0|6|.

14. REPRESENT ENTIRE FAMILY - (PLAN) The Plan should indicate whether or not the number of persons enrolled represents the respondent's entire family. IF NO ONE ENROLLED, MARK NOT APPLICABLE. 1=Yes, 2=No, 3=Not Applicable.

15. NUMBER OF PERSONS NOT ENROLLED - (PLAN) If No (2) on 14, this does not represent the entire family, enter the number not enrolled.

16. EXPLAIN NON-ENROLLING FAMILY MEMBERS - (PLAN) If applicable state reasons for non-enrolling family member(s).

17. NUMBER OF TIMES CONTACTED - (PLAN) The plan should indicate the total times the individual was contacted by them. Example - 4 visits would be |0|4|. See General Specifications for definition of a contact.

NOTE: IF THERE WAS MORE THAN ONE CONTACT, THE PLAN SHOULD FILL IN ITEMS # 17-19, IF NOT, THESE ITEMS SHOULD BE LEFT BLANK. BE SURE NOT TO MARK THE RESPONDENT AS ENROLLING ON BOTH CONTACTS.

18. DATE OF LAST CONTACT - (PLAN) The Plan should indicate the date of their last contact with the individual in the following order - month, day, year. Example - April 10, 1979 would be -|0|4|1|0|7|9|.

19. METHOD OF LAST CONTACT - (PLAN) The Plan should indicate the method used on their last contact with the individual with - 1=phone call, 2=mailed material, 3=home visit, 4=walk-in (respondent walks into Plan, self referred.

20. RESULTS OF LAST CONTACT - (PLAN) The Plan should indicate the results of their last contact with the individual with - 1=verified enrollee, 2=enrolled in another Plan, 3=no contact, 4=decision pending, 5=stay on regular Medi-Cal, 6=other. BE SURE NOT TO MARK THE RESPONDENT AS ENROLLING ON BOTH CONTACTS.

FORMS CYCLE--BIF, CAPIF, RIF, & PFIF
(Routing, Batching and Logging)

	ACTION	RESPONSIBLE PARTY	NARRATIVE
1.	Route	TSG to F.R.	Forms are printed and distributed to MEMS by the TSG. Brochures must be included as appropriate for each site. Field Reps. will be responsible for scheduling the number and types of forms needed for their respective plans. This information should be kept current with the TSG via the field supervisor.
2.	Route	F.R. to W.O.	Forms will be given to the plans and the Welfare Offices by the Field Reps. Field Reps. should make sure that enough BIF, CAPIF and brochure forms are available to the Plans and offices so as not to interrupt the demonstration.
3.	Route	W.O. to client	BIFs will be mailed or given to selected individuals prior to their eligibility appointments in a predetermined manner. The selection of individuals for the demonstration and the sequencing and timing of form distribution will be agreed upon in the procedures written for each Welfare Office. These procedures will conform as closely as possible to those outlined in Field Data Specificiations.
4.	Batch	Presenter to F.R.	The person responsible for conducting the presentation will make sure that the BIF is properly and completely filled out prior to discussing the choice with clients. Following the presentation, the presenter will be responsible for: making sure the CAPIF is completed properly and that it and the BIF are attached together and placed in the PHRED box or given to the Field Rep. In case of handout only, or A.V., a responsible person will be designated by the Field Reps. In all cases, it will be the Field Rep's., responsiblity to assign someone to do a follow-up or make other arrangements for corrections.
5A.	Route	F.R. to MEMS Clerk	The Field Reps. will pick up the forms in the PHRED box from the Welfare Offices on a weekly basis. The forms will be edited by the Field Reps. and checked for completeness. F.R. completes forms as needed and brings them weekly to the Project office. Information and findings aside from forms are entered on a weekly report to the Field Supervisor. Field Representatives will give all forms to the MEMS Clerk.

	ACTION	RESPONSIBLE PARTY	NARRATIVE
6.	Sort	MEMS Clerk	MEMS Clerk daily sorts incoming documents (BIF/ CAPIF) into two files; (1) FFS & (2) PHP.
7.	Edit	MEMS Clerk	MEMS Clerk edits completeness and content of BIF and CAPIF. Where incomplete they are returned via Field Supervisor to the responsible Field Rep. for completion, use a route slip designated for this purpose. Edit-Completeness/Content a. Name/Address b. Decision (PHP/FFS) c. Complete Medical No. (14 digit) (for all persons) d. Signature (For PHP choice only) e. All items clearly marked f. Other logic errors-(EX: CAPIF-Items 9-14 filled out on a "Printed Material only" day).
8.	Process	MEMS Clerk	MEMS Clerk stamps control number (See General Spec.: W.O.) on each document in the two piles.
9.	Route	MEMS Clerk to Plan	On the day of delivery to PHRED MEMS Clerk of complete forms or as soon as possible, the MEMS Clerk will locate all persons choosing PHPs and send the original copy of the CAPIF to the plan(s). Documents will be returned from the field with the CAPIF on top for PHP choosers. A copy of this will be kept at PHRED for key entry. A Referral Information Form (RIF) will go along with the CAPIF to the Plan(s). The RIF will be returned to PHRED within 21 days from the day of the receipt of the other information. The same control number should appear on the RIF as appears on the BIF and CAPIF.* A prelabeled envelope should be available for sending documents to plans.
10.	Batch (Cover Sheet)	MEMS Clerk	The MEMS Clerk breaks down PHP and FFS piles into batches. Each batch may contain no more than 99 sets of forms. A Batch Cover Sheet is prepared for each batch. This identifies each document in the batch and allows for the completion status of PFIF & RIF. Once complete it accompanies batch to KDE. A copy should be kept to control document flow to KDE.
11.	Batch (Log)	MEMS Clerk	The MEMS Clerk controls the document flow to KDE via this log. This is kept at PHRED and tracks the flow of data to and from KDE. When all batches on the page have been returned, a check in the upper right hand corner is added. (See General Specs.).

	ACTION	RESPONSIBLE PARTY	NARRATIVE
12.	Follow-Up	MEMS Clerk	The MEC will check the batch and files log to establish which clients require a phone follow-up interview. The criteria for the follow-up should be: (1) those persons going through the process on a particular day, approximately 15 days before the current date. (See General Specifications), (2) all persons choosing to enroll in a PHP and, (3) a 20% sample of persons choosing regular Medi-Cal. (See General Specifications). If no contact is made with the client, the procedures outlined in General Specifications, should be followed. The MEC should enter on the Batch Cover Sheet that a phone follow-up has occured. As they are completed, batches may be submitted to KDE.
13.	Edit	MEMS Clerk	The returning RIF will be checked for completeness and marked off the Batch Cover Sheet and filed with its batch. This will require periodic calls to the Plans for additional data.
14.	Route	MEMS Clerk to Key Entry via TSG	The MEMS Clerk will route completed BIF, CAPIF, PFIF, and RIF forms for PHP and FFS to Key Entry via TSG on a flow basis. BIF, CAPIF, PFIF and RIF should be held until they can be submitted together.
15.	Route	TSG to MEC	The TSG will return all hard copies to MEMS for storage and reference.

* This process was later altered to include a RIF listing which MEMS field staff was to maintain which allowed the central office to generate a RIF and copy which allowed for closer monitoring.

General Specifications
Marketing Demonstration Data Collection

Welfare Office

1. For each marketing process at a demonstration site, it is necessary that each type of form be handled consistently for all marketing methods. That is, each type of form should be completed at the same point in the process for every marketing method presented in a particular site. For example, all the subjects processed in the Alameda office should complete the BIF at the same point in the processing no matter what marketing method is being used; similarly the CIF, MIF, etc., will be filled out at specific points designated for each of them.

2. The Basic Information Form (BIF) should be completed before the marketing presentation (including pamphlet).

3. The Choice and Presentation Information Form (CAPIF) must be completed after the marketing presentation (including pamphlet).

4. Items 1-6 at the bottom of the CAPIF will be completed by County personnel when the printed material is supposed to be given to the client. If the marketing presentation is scheduled for a different time, then the PIF should be placed in the client's folder and items 7-14 completed at the time of the presentation. Additionally, during the County Worker Method items 12 and 13 should be completed. Item 14 should be signed regardless of method.

   Only persons who can directly observe the delivery of the printed material should answer items 4 and 5. Similarly items 7 to 11 should only be answered by persons who directly observe the marketing presentation. It is advisable for County or State personnel to maintain control of these forms, even if they have to ask PHP personnel for some of the information.

   When CAPIF is returned with the BIF to the Project, it should be on top for PHP choosers to facilitate the additional task of photocopying for Project use.

5. The Phone Follow-Up Information Form (PFIF) should be completed between (two) and (four) weeks after the time of choice. The interviewer should, for FFS follow-ups, make (two-four) attempts to contact person before the call is considered as unsuccessful and listed as "no contact". This depends on the backlog. For PHP choosers, as they are fewer, all possible efforts should be made to reach them. A form letter was developed for this purpose.

   An unsuccessful attempt to contact is any correctly dialed call in which (1) the phone is not answered within 10 rings, (2) the subject (client) is known at that number but is not present during the call, or (3) the subject is present but chooses to participate at another time. No more than one attempt per day should be made to contact any particular subject; the time and day should be varied. Oftentimes early in the morning and in the evening is a good time to catch a person.

If a person sounds willing, but unable at that time to talk, then try to schedule a time that would be convenient to them.

In the event of an excessive backlog of uncompleted telephone follow-up questionnaires for FFS clients, the required number of "tries" for contact should be reduced from four to two. Sampling should follow procedures detailed below until a sufficient number of contacts have been made.

6. PHRED headquarters personnel will complete items #1 to #9 of the Referral Information Form (RIF) and send the form to the proper plan(s). The plan will complete items #10 to #19 and return the form to PHRED headquarters within 21 days of the date specified in item #9. The plans must make at least two unsuccessful attempts to contact the subject (client) before the RIF is returned to PHRED as "no contact" case.

   For the plan an unsuccessful attempt is a correctly dialed phone call or an in-person visit to the address listed on the RIF in which (1) no one is home, (2) subject is known at that place but is not present, or (3) subject is present but wants to discuss the plan at another time. If the subject's phone number of address is listed incorrectly on the RIF, then call PHRED headquarters to obtain a correction.

7. Welfare Office - The stamping of control numbers using the seven-digit automatic numbering machine works as follows. The number will be stamped in the upper right hand corner of each form within or close to the pre-printed number block. The number will appear as:

|___|__|__|___|___|_____|_____|
Julian Date Batch No. Sequence No.

   A. Julian Date - three digit less the year. Date used is the date received at PHRED.

   B. Batch No. - (00-99) this is the number which identifies the batch of a particular set of documents. In one day's processing there should not be more than 99 batches. Batch No. 00-49, will be used to further a FFS batch while, Batch No's. 50-99 will identify a PHP batch.

   C. Sequence No. - (00-99) a sequence number is a number from 1 to 99 given to a document within a batch.

   D. Numbering via the automatic numbering machine works as follows:

      1) Set the Julian to the processing date (most office calenders have the Julian date at the lower corner).

      2) Set the batch number (00-49 for FFS and 50-99 for PHP).

      3) Sequence Number - set to zero and duplicate. The machine will increase by one to 99 as every other form is stamped.

8. Batching - (See attached sample form)

   A. For each batch a "Batch Cover Sheet" is attached. This identifies the sequence number of each document and provides space for indicating the completion status of the PFIFs and whether or not the RIF has been sent. These have been preprinted to allow for 00-99 documents in the batch and the method applicable.

      This cover sheet stays with the batch and when PFIFs and RIFs are completed, it can be forwarded to KDE for processing.

      1) Batch number is entered at the top of the form. (00-49 for FFS and 50-99 for PHP).

      2) Box indicating batch type is also checked and method for that document.

      3) Number of documents in batch is entered.

      4) Routing status - when batch for KDE with (PFIF & RIF) enter date to KDE and date returned.

      5) The general rule for batching is to date when a RIF or PFIF is due and check it off once it has been returned.

   B. Batch Log Sheet - this form or these items are kept at PHRED to keep track of data flow to and from KDE.

      1) Batch Control No. - enter the batch number (00-49 for FFS and 50-99 for PHP).

      2) No. in Batch - enter number of completed document sets in batch.

      3) Batched By - initial of person batching.

      4) Date - date of batch.

      5) Status - check and date indicating whether the batch has gone to KDE, and check and date when it was returned to KDE. More than one day's work can be entered on the sheet.

      6) Comments - problems, etc., with an individual batch.

      7) When all batches on the page have been returned, a check can be made in the upper right-hand corner.

9. Sample - for PHP enrollees in any of the three major methods we will not be sampling, rather we will be getting information on as many as possible.

   As the FFS population is much larger, we will be sampling approximately 20 percent of the persons who choose this type of Medi-Cal. Procedures for the latter are as follows:

A. W.O. - From the FFS Batch Cover Sheet approximately 20 persons per batch should be identified and followed up with a phone call (PFIF). To select which persons, the table of random numbers is attached. Starting at the number marked, go down the column and begin at the top of the next column, selecting those persons who have sequence numbers coresponding to those in the column of the random number table until 20 have been selected.

If an FFS batch has much less than 20 persons total then, the following guide should be used:

1-10 all

11-20 every other one

21-? go to table down the column looking for number within the range.

Mail

1. PHRED headquarter's personnel will complete items #1 to #12, Mail Information Form (MIF) and send the form to the proper plan(s). The plan(s) will complete items #4 to #21 and return the form to PHRED headquarters within 21 days from the date in item #3 (deadline date shown in item #12). The plans must make at least two unsuccessful attempts to contact the subject (client) before the MIF is returned to PHRED as a "no contact" case.

   An unsuccessful attempt is a correctly dialed phone or an in-person visit to the address listed on the MIF in which (1) no one is home, (2) subject is known at that place but is not present, or (3) subject is present but wants to discuss the plan at another time. If the subject's phone number or address is listed incorrectly on the MIF, then call PHRED headquarters to obtain a correction.

2. For the MIF, item #8, and the MIF item #10B, ("Please contact this person within XX days"), the number of days has been set at 21.

3. Control numbers - Batch and sequence numbers work the same for the mail method as for other methods.

   A. Julian Date - Three digits less the year. Date used is the date processed at PHRED.

   B. Batch No. - (00-99) this is the number which identifies the batch of a particular set of documents. In one day's processing there should not be more than 99 batches. Batch No. 01-49, will be used to further a FFS batch, while Batch Nos. 50-99 will identify a PHP batch.

C. Sequence No. - (00-99) a sequence number is a number from 1 to 99 given to a document within a batch.

D. Numbering via the automatic numbering machine will work as follows:

1) Set the Julian to the processing date (most office calenders have the Julian Date at the lower corner).

2) Set the batch number - (00-49 for FFS and 50-99 for PHP).

3) Sequence Number - Set to zero and duplicate. The machine will increase by one to 99 as every other form is stamped.

For PHP choosers the forms requiring stamping with the automatic numbering machine are:

- MIF copy
- Choice Card copy
- PFIF

For FFS sample:

- Choice Card only
- PFIF

For all PFIFs for PHP choosers and FFS sample, enter the mail label number appearing on the lower right side of the Choice Card in the space provided on the upper right corner. This allows the MEMS Clerk to process more than one mailing into the same batch.

4. Batching - (See attached sample forms)

A. For each batch sheet a "Batch Cover Sheet" is attached. This identifies the sequence number of each document and provides space for indicating the completion status of the PFIF and whether or not the MIF has been sent.

This cover sheet stays with the batch and when PFIFs are completed, it can be forwarded to KDE for processing.

1) Batch number is entered at top of the form (00-49 for FFS and 50-99 for PHP).

2) Box indicating batch type is also checked.

3) Number of documents in batch is entered.

4) Routing status - When batch is ready, PFIF is complete and MIF sent to Plan, then batch is ready for key entry - enter date. Returned from key entry - enter date.

B. Batch Log Sheet - This form or these items are kept at PHRED to keep track of data flow to and from KDE.

1) Batch Control No. - Enter the batch number (00-49 for FFS and 50-99 for PHP).

2) No. in Batch - Enter number of completed document sets in batch.

3) Batch By - Initial of person batching.

4) Date - Date of batch.

5) Status - Check and date indicating whether the batch has gone to KDE, and check and date when it was returned from KDE. More than one day's work can be entered on the sheet.

6) Comments - Problems, etc., with an individual batch and plan being selected.

7) When all batches on the page have been returned, a check can be made in the upper right-hand corner.

5. Sampling

Incoming FFS Choice Cards are sorted by mail batch (B, C, D, E, F, G, H, I, and J) and date returned to PHRED. Once assembled in this fashion a day's returns should be sampled in the following manner:

If total FFS returns have 20 or less persons total returns for the day then, the following guides should be used:

1-10 all
11-20 every other one

If returns for one day amount to substantially more than 20, which they will at peak periods, the following should be used:

Volume of Returns	Number of Persons To Be Sampled	Sample Interval	
100	20	Every 5th one	If total falls between, go to higher number
200	30	Every 6th one	
300	40	Every 7th one	If total falls between, go to lower number of persons
400			
500	50-60	Every 8th one	

Selection of any particular case for follow-up requires that a phone number be listed on the card. If not, select the next case in front of or behind the one selected.

Once selected into the sample, the Choice Card should be photocopied and stamped with the appropriate number. A blank PFIF should be stamped with the same number and the mail sequence number entered in the upper right-hand corner of the form.

6. Special Mailing/Mailing Guidelines

   - o If no choice is indicated, phone beneficiary or send a letter.
   - o If contact is not possible and no choice is indicated, send choice card to the plan.
   - o Choice but no signature, to MEMS, letter to beneficiary with new card for signature. Card back, make copy, enter in log, fill out MIF.

In the event of an excessive backlog of uncompleted telephone follow-up questionnaires for FFS clients, the required number of "tries" for contact should be reduced from 4 to 2. Sampling should follow procedures detailed above until a sufficient number of contacts have been made. This should last until the backlog has been reduced.

Current Method

1. Batch and sequence number (See W.O.).

2. Sampling - To select the appropriate number of FFS phone follow-ups, the total number of contacts have to be found. As Street Sheets are returned by plan, after filling out PRFs on all valid contacts count the number of total FFs valid contacts. Take 20 percent of that number (Ex: 20 percent of total of 100 contacts = 20). This provides the top end of the sample. To find which 20 should be included in the sample, go to the table of random numbers starting from the number underlined in blue, proceed across the column until a number is found that is within the range. Going back to the Street Sheet starting at the beginning, select that contact which corresponds to the number from the random number chart. If the contact choosen has incomplete information (Ex: no phone), return to the table and take the next number. As in the W.O. the same bottom limit applies.

   If an FFS batch has much less than 20 persons total, then the following guide should be used:

   1-10 All
   11-20 Every other one
   21-? Go to table, down the column looking for number within range.

Method

BATCH COVER SHEET
Membership Studies

☐ W.O.

☐ MAIL

☐ C.M.

BATCH NUMBER: _____

Number of Documents in this batch: ____

PHP	FFS

SEQUENCE NUMBERS	RIF/MIF	SEQUENCE NUMBERS	RIF/MIF

ROUTING/STATUS

____ To Key Entry _____ date

____ Returned from Key Entry _____ date

KDE SUBMISSION REQUIREMENTS

1. Batch/sequence number should be clear and unambigious at the upper right hand corner of the top form.

2. The form type must follow the number. On some forms they are preprinted. If the form you are using is not, code as necessary-
   BIF = B
   CAPIF = C
   RIF = R
   MIF = M
   PFIF = F
   PRF = P

3. Before submission check all forms to insure that the forms are readable and the numbers are clearly visible. This includes items that the client has billed out as well as that which PHRED staff has filled out.

4. Special Codes on the CAPIF #7-#10, and PFIF items #15, 22, 23, 24A, 24B, 24C, 24D, 24E, 24F, 25A, and 25B have been coded.

5. Blank items should be left blank.

6. When coding the following should be used:

   - o If blank, leave blank
   - o Right justify single digit if in two or more digit fields
   - o Respondents should be encouraged to answer or guess if need be. Do not settle for the initial "Well, I don't know"

7. When to call the batch complete: If all reasonable efforts have been made to complete the batch and:

   - o It is more than 60 days old (from the time documents were first received at PHRED)
   - o At least 75% of the batch is complete

Order - W.O.
1. Batch Cover Sheet and General Services Data Transmittal (DPSO-9)
2. Basic Information Form
3. Choice and Presentation Information Form
4. Referral Information Form

CM
1. Batch Cover Sheet and General Services Data Transmittal (DPSO-9)
2. Presentation Information Form
3. Phone Follow-Up Information Form

Mail
1. Batch Cover Sheet and General Services Data Transmittal (DPSO-9)
2. Choice Card Copy
3. Mail Information Form
4. Phone Follow-Up Information Form

Coding Instructions
Phone Follow-Up (Code in Right Hand Column)

ITEM	SECTION I - CODE - ALL RESPONDENTS
1	Method of Contact: 1 = By Mail 2 = At home 3 = Social Service Office 4 = Other
2A	Join a PHP 1 = Yes 2 = NO
2B	Regular Medi-Cal 1 = Yes 2 = No
3	Agreement to Interview 1 = Yes 2 = No 3 = No, refuse interview
	SECTION II - MAIL RESPONDENTS ONLY
4	What did you think you had to do when you received the mailing 1 = Enroll in plan 2 = Get more information 3 = Send back card 4 = Nothing 5 = Other
5	Did mailing help you? 1 = Yes 2 = No 3 = Other
	SECTION III - MAIL - CURRENT METHOD
6	Head of Household 1 = Yes 2 = No

7 How old are you?
00 - 99

8 Marital Status
1 = Married
2 = Divorced
3 = Single
4 = Separated
5 = Widowed
6 = Other

9 Highest grade in school?
00 - 99

10 Children in Household?
00 - 99

11 Age of Youngest Child?
00 - 99

12 Age of Oldest Child?
00 - 99

13 Language spoken at home?
1 = English
2 = Spanish
3 = Other

14 Ethnicity
1 = Asian
2 = Black
3 = Filipino
4 = Hispanic
5 = Native American
6 = White
7 = Other

SECTION IV - ALL PERSONS, HEALTH

15 Do you have a family doctor right now?
1 = Yes
2 = No

16 Satisfaction with current care?
1 = very satisfied
2 = satisfied
3 = so-so
4 = dissatisfied
5 = very dissatisfied

17 How many times seen a doctor in last year
00 - 99

18 How may times other members of the household seen doctor in the last year?
00 - 99

19 How many times hospitalized in the last year?
00 - 99

20 How many times household members hospitalized in last year?
00 - 99

21 Need medical care right now?
1 = Yes
2 = No

ITEM	SECTION IVB - CHOICE FACTORS - ALL

22 Heard of pre-paid health plans before?
1 = Yes
2 = No
3 = Don't know

23 Have you or anyone in your household ever joined a PHP before?
1 = Yes
2 = No
3 = Don't know

24 *A Main reason for joining a PHP
0 - 9 (codes to be devised)

B Services under one roof
1 = Yes
2 = No
3 = Other

*C What other reasons were important to you
0 - 9 (codes to be devised)

*D Stay on regular Med-Cal
0 - 9 (codes to be devised)

E Was it important to keep your own doctor?
1 = Yes
2 = No
3 = Other

F What other reasons were important to you?
0 - 9 (codes to be devised)

25 *A What is the most important thing PHP's should do for you?
0 - 9 (codes to be devised)

*B What is the most important thing that regular Medi-Cal should do for you?
0 - 9 (codes to be devised)

ITEM SECTION V - VERIFICATION - ENROLLEES

26 Has anyone from the health plan called or come by to see you to ask if you have questions about services?
1 = Yes, phone
2 = Yes, home (face to face)
3 = Yes, other
4 = No

27 Have you received a plan booklet explaining the services available?
1 = Yes
2 = No
3 = Don't know

28 Do you understand that joining the plan was completely voluntary and that you don't have to enroll to keep your food stamps or aid?
1 = Yes
2 = No
3 = Don't know

29 A. Do you understand that after the first 30 days you can disenroll (get out) for any reason?
1 = Yes
2 = No
3 = Don't know

29 B. Do you understand that after the first 30 days you can disenroll if you are dissatisfied after you use the plan's grievance system?
1 = Yes
2 = No
3 = Don't know

30 Did anyone check to see if you were under a doctor's care?
1 = Yes
2 = No
3 = Don't know

31 Do you understand that after your enrollment begins you can't go back to your current doctor unless he or she is on the list?
1 = Yes
2 = No
3 = Don't know

32 Your enrollment will probably be effective _____, you will know because you won't get your Medi-Cal card and the plan will send you an ID card instead. Until then do you know how to get health care?

1 = Yes
2 = No
3 = Don't Know

SECTION VI - COMPREHENSION QUESTIONS - ALL

33 Pre-paid health plans are part of Medi-Cal?

True = 1
False = 2
Don't know = 3

34 Both regular Medi-Cal and pre-paid Medi-Cal provide basic health care at no cost to you?

True = 1
False = 2
Don't know = 3

35 People who are eligible for Medi-Cal may choose between regular Medi-Cal and pre-paid Medi-Cal?

True = 1
False = 2
Don't know = 3

36 Sometimes PHPs offer extra services that regular Medi-Cal doesn't?

True = 1
False = 2
Don't know = 3

37 People who use regular Medi-Cal have to use the same doctor all the time?

True = 1
False = 2
Don't know = 3

38 If you are using pre-paid Medi-Cal, you must go to that plan's facilities except in emergencies when you can't get there?

True = 1
False = 2
Don't know = 3

39 People on Medi-Cal who go to PHPs are guaranteed health care by the plan?

True = 1
False = 2
Don't know = 3

40 PHPs allow their members to go anywhere they want for health care?

True = 1
False = 2
Don't know = 3

41 People using regular Medi-Cal must find their own doctor?

True = 1
False = 2
Don't know = 3

42 It may take approximately 60 days to disenroll from a pre-paid health plan?

True = 1
False = 2
Don't know = 3

43 Correct address?

1 = Yes
2 = No

44 Interviewer:

01 = Marguerite
02 = Suzanne
03 = Bob
04 = Kathy
05 = Anthony
06 = Tom B.
07 = Jo

45 Date of interview:

Code Julian (000 - 365)

46 Time of day:

(Code actual clock time)

47 Number of tries:

01 - 99

48 Interview time:

Code minutes: 01 - 99

CAPIF - TO BE CODED BEFORE KDE

ITEM NO.	QUESTION	CODE
7	"Plan Chosen"	On left hand margin write numeric code for appropriate plan. Contra Costa = 45 HealthCare = 86 Rockridge = 63 Watts = 32 CompreCare = 22 CMGHP (LA) = 2 CMG (ORANGE) = 23 Kaiser (LA) = 28 Kaiser (Orange) = 26 HMOC = 82 N. E. Valley = 55
10	"If no why different for some members?"	0 = No answer 1 = Don't know about this program. 2 = Other established provider. 3 = Bettr care. 4 = For child only. 5 = Inconvient to change. 6-8 = Use as needed. 9 = Other
	PFIF	
15	No, then probe-where do you get most of your care right now?	1 = Yes 2 = No, no comment 3 = No, new to the area 4 = No, no where 5 = No, emergency (ER) county hospital/clinic
22	Probe: Had you heard you heard of prepaid health plans before you were contacted.	1 = Yes, no comment 2 = No 3 = Heard positive comments about it at work. 4 = Heard positive comments from another (friend, relative) 5 = heard negative comments about it at work 6 = Heard negative comments about it from another (friend, relative) 7 = Solicited at home 8 = Solicited on the street 9 = Yes, other

PFIF - TO BE CODED BEFORE KDE

ITEM NO.	QUESTION	CODE
23	Probe: Have you or anyone else in your household ever joined a PHP before.	1 = Yes, no comment 2 = No 3 = Lost eligibility 4 = Inadequate service 5 = Unqualified staff 6 = Transportation/bad location 7 = Doctor switching 8 = Pressured to join 9 = Like regular Medi-Cal 10 = Dislike regular Medi-Cal 11 = Previously enrolled/familiar 12 = Yes, other
24A	What would you say is the main reason why you decided to join PHP?	0 = No reason 1 = More/better services 2 = Convient 3 = Previous enroll/familar 4 = No current source of care 5 = Dissatisfied with regular Medi-Cal care 6 = 7 = 8 = 9 = Other
24B	Was it important to your to have all services under one roof?	1 = Yes, no comment 2 = No 3 = Convient but not important 4 = Helps but of only moderate concern 5 = Very important if in one place 6 = 7 = 8 = 9 = Other

ITEM NO.	QUESTION	CODE
24C	What other reasons were important to you?	0 = None 1 = Centralized services 2 = More services 3 = Regular Medi-Cal too complicted 4 = Convient 5 = Care always available 6 = 7 = 8 = 9 = Other
24D	Stay on regular Medi-Cal	0 = None 1 = Established provider 2 = Allows use of any doctor/hospital that takes Medi-Cal 3 = Allows freedom of choice of health care provider (use it anywhere) 4 = Convient/fewer problems 5 = More immediate attention 6 = Special services 7 = 8 = 9 =Other
24E	Was it important to choose your own doctor?	0 = No answer 1 = Yes, no comment 2 = No 9 = Other
24F	What other reasons were important to you?	0 = None 1 = No waiting time, lines or crowds 2 = Use any doctor/hospital 3 = Keep current provider 4 = More/better services 5-8 9 = Other

ITEM NO.	QUESTION	CODE
25A	PHP's should do for you?	0 = No reason given 1 = Provide more/better services 2 = Preventative care 3 = Reduced waiting time/lines or crowds 4 = More better/qualified staff 5-7 8 = Other 9 = Don't know/not sure
25B	Regular Medi-Cal should do for you?	0 = No reason 1 = Provide more/better services 2 = Provide adequate care 3 = Dental 4 = Preventative care 5 = Rx more extensive 6-7 8 = Other 9 = Don't know/not sure

PHRED PROJECT
DETAIL DESIGN DOCUMENTATION
I N P U T D E S C R I P T I O N

INPUT NAME
MEMS WELFARE OFFICE

INPUT ID
HSA00-52

RECORD NAME
BASIC INFORMATION FORM (BIF)

RECORD NO. RECORD SIZE
503

FIELD NUMBER	DATA ELEMENT NUMBER	FIELD NAME	PROCEDURE INSTRUCTIONS	FIELD SIZE	DATA TYPE	POSITION FROM	POSITION THRU
001	ID	Identification	RNFF	7	N	1	7
002	IDF	Form Type (B or Blank)	PAS SNE	1	A	8	8
003	1	Name (Last, First Middle)	TTF	14	A	9	22
XX		Address	--	--	-	-	--
004	2	Street Number (Right Justify)	RJ	5	N	23	27
005	2	Street/Road	TTF	14	A	28	41
006	2	City/County	TTF	14	A	42	55
007	2	Zip Code	RJ	5	N	56	60
008	3	Phone Number	PAS	10	N	61	70
009	4	Birthday (MMDDYY)	PAS SNE	6	N	71	76
010	5	Sex (Female-1, Male-2)	PAS SNE	1	N	77	77
011	6	Marital Status 1-Married, 2-Divorced 3-Separated, 4-Widowed 5-Single, 6-Other	Punch Value for Code Checked	1	N	78	78
012	7	Language Spoken at Home 1-English, 2-Spanish, 3-Other	Punch Value for Code Circled	1	N	79	79
013	8	Ethnicity (1-7) 1-Asian, 2-Black, 3-Filipino, 4-Hispanic 5-Native American, 6-White, 7-Other	Punch Code for Item Circled	1	N	80	80
014	9	Highest Grade in School 0-16 more than 16	Punch Value Circled	2	N	81	82
015	10	How many children seeking aid for 0-12 more than 12	Punch Value Circled	2	N	83	84
016	11	Age of Oldest Child (0-19, more than 19)	Punch Value Circled	2	N	85	86
017	12	Age of Youngest Child (0-19, more than 19)	Punch Value Circled	2	N	87	88

PHRED PROJECT
DETAIL DESIGN DOCUMENTATION
I N P U T D E S C R I P T I O N

INPUT NAME
MEMS WELFARE OFFICE

INPUT ID

RECORD NAME
BASIC INFORMATION FORM (BIF)

RECORD NO. RECORD SIZE

FIELD NUMBER	DATA ELEMENT NUMBER	FIELD NAME	PROCEDURE INSTRUCTIONS	FIELD SIZE	DATA TYPE	POSITION FROM	POSITION THRU
018	13	Regular source of health care 1-Yes, 2-No	Punch Code for Item Checked	1	N	89	90
019	14	Usual source of care 1-Private Doctor 2-County Clinic 3-County Hospital 4-Emergency Room 5-HMO/PHP, 6-Other	Punch Code for Item Checked	1	N	91	91
020	15	Do you or any persons for who you are seeking aid need medical care now 1-Yes, 2-No	Punch Code for Item Checked	1	N	92	92
021	16	Heard of health maintenance organization 1-Yes, 2-Not Sure, 3-No	Punch Code for Item Checked	1	N	93	93
022	17	Belong to an HMO/PHP before 1-Yes, 2-Not Sure, 3-No	Punch Code for Item Checked	1	N	94	94

PHRED PROJECT
DETAIL DESIGN DOCUMENTATION
I N P U T D E S C R I P T I O N

INPUT NAME
MEMS WELFARE OFFICE

INPUT ID

RECORD NAME
CHOICE AND PRESENTAITON INFORMATION FORM (CAPIF)

RECORD NO. RECORD SIZE

FIELD NUMBER	DATA ELEMENT NUMBER	FIELD NAME	PROCEDURE INSTRUCTIONS	FIELD SIZE	DATA TYPE	POSITION FROM	POSITION THRU
023		Form Type (C)	Enter 'C' as constant	1	A	95	95
		CHOICE INFORMATION					
024	1A1	Relation (self,father, mother, son, daughter)	PAS SNE	8	A	96	103
025	1A2	HMO/Card	Punch Value Checked	3	A	104	106
026	1A3	Medi-Cal Number	LJ if not FF	14	N	107	120
027	1A4	Birthday (MMDDYY)	PAS SNE	6	N	121	126
028	1A5	Sex (M or F)	PAS SNE	1	A	127	127
029	1B1	Relation (father, son, daughter, mother)	PAS	8	A	128	135
030	1B2	HMO/PHP	Punch Value Checked	3	A	136	138
031	1B3	Medi-Cal Number	LJ if not FF	14	N	139	152
032	1B4	Birthday (MMDDYY)	PAS SNE	6	N	153	158
033	1B5	Sex (M or F)	PAS SNE	1	A	159	159
034	1C1	Relation (father, son, daughter, mother)	PAS	8	A	160	167
035	1C2	HMO/PHP	Punch Value Checked	3	A	168	170
036	1C3	Medi-Cal Number	LJ if not FF	14	N	171	184
037	1C4	Birthday (MMDDYY)	PAS SNE	6	N	185	190
038	1C5	Sex (M or F)	PAS SNE	1	A	191	191
039	1D1	Relation (father, son, daughter, mother)	PAS	8	A	191	199
040	1D2	HMO/PHP	Punch Value Checked	3	A	200	202
041	1D3	Medi-Cal Number	LJ if not FF	14	N	203	216
042	1D4	Birthday (MMDDYY)	PAS SNE	6	N	217	222
043	1D5	Sex (M or F)	PAS SNE	1	A	223	223
044	1E1	Relation (father, son, daughter, mother)	PAS	8	A	224	231
045	1E2	HMO/PHP	Punch Value Checked	3	A	232	234
046	1E3	Medi-Cal Number	LJ if not FF	14	N	235	248
047	1E4	Birthday (MMDDYY)	PAS SNE	6	N	249	254
048	1E5	Sex (M or F)	PAS SNE	1	A	255	255

PHRED PROJECT
DETAIL DESIGN DOCUMENTATION
I N P U T D E S C R I P T I O N

INPUT NAME
MEMS WELFARE OFFICE

INPUT ID

RECORD NAME
CHOICE AND PRESENTATION INFORMATION FORM (CAPIF)

RECORD NO. RECORD SIZE

FIELD NUMBER	DATA ELEMENT NUMBER	FIELD NAME	PROCEDURE INSTRUCTIONS	FIELD SIZE	DATA TYPE	POSITION FROM	POSITION THRU
049	1F1	Relation (father, son, daughter, mother)	PAS	8	A	256	263
050	1F2	HMO/PHP	Punch Value Checked	3	A	264	266
051	1F3	Medi-Cal Number	LJ if not FF	14	N	267	280
052	1F4	Birthday (MMDDYY)	PAS SNE	6	N	281	286
053	1F5	Sex (M or F)	PAS SNE	1	A	287	287
054	1G1	Relation (father, son, daughter, mother)	PAS	8	A	288	295
055	1G2	HMO/PHP	Punch Value Checked	3	A	296	298
056	1G3	Medi-Cal Number	LJ if not FF	14	N	299	312
057	1G4	Birthday (MMDDYY)	PAS SNE	6	N	313	318
058	1G5	Sex (M or F)	PAS SNE	1	A	319	319
059	7	Plan choosen (Plan number coded middle of page)	PAS	2	N	320	321
060	8	Method of Contact 1-Home, 2-By Phone, 3-Mail	Punch Value Checked	1	N	322	322
061	9	Other Health Insurance 1-Yes, 2-No, 3-Don't Know	Punch Value Checked	1	N	323	323
062	10	Decision for all family members the same 1-Yes, 2-No	Punch Value Checked	1	N	324	324
063	10A	Why is it different for some members (Code 0-9)	PAS SNE	1	N	325	325
064	11	Health care in an HMO/PHP 1-Better Than Now 2-About the Same 3-Not as Good	Punch Value Checked	1	N	326	326
065	1	Office (Site Location) 1-Pittsburg,2-Richmond 3-Oakland, 4-Sacramento County, 5-East Valley, 6-Florence, 7-Orange	Punch Value Checked	1	N	327	327

PHRED PROJECT
DETAIL DESIGN DOCUMENTATION
I N P U T D E S C R I P T I O N

INPUT NAME
MEMS WELFARE OFFICE

INPUT ID

RECORD NAME
CHOICE AND PRESENTATION INFORMATION FORM (CAPIF)

RECORD NO. RECORD SIZE

FIELD NUMBER	DATA ELEMENT NUMBER	FIELD NAME	PROCEDURE INSTRUCTIONS	FIELD SIZE	DATA TYPE	POSITION FROM	POSITION THRU
066	2A	Type of Case 1-Intake, 2-Re-evaluation, 3-Aid Code Change, 4-Other	Punch Value Checked	1	N	328	328
067	3	Aid in Last Six Months 1-Yes, 2-No	Punch Value Checked	1	N	329	329
068	4A	Client received printed mateiral 1-In Advance 2-Day of Presentation 3-None Shown	Punch Value Checked	1	N	330	330
069	4B	Did client report reading the material 1-Yes, 2-No	Punch Value Checked	1	N	331	331
070	5	Did the client require a translator to understand the written or oral presentation 1-Yes, 2-No	Punch Value Checked	1	N	332	332
071	6	Date of Presentation (MMDDYY)	PAS SNE	6	N	333	338
072	7	Presentation Setting 1-Individual, 2-Group, 3-Couple, 4-Other	Punch Value Checked	1	N	339	339
073	8	Type of Presentation 1-Printed Material, 2-EN, 3-HMO Rep., 4-AV (Film), 5-State Worker, 6-None	Punch Value Checked	1	N	340	340
074	9	Presentation Started (XX:XX)	PAS SNE	4	N	341	344
075	10	Presentation Ended (XX:XX)	PAS SNE	4	N	345	348
076	11	Total Presentation Time	PAS SNE	3	N	349	351
077	12	Total E.W. Time	PAS SNE	3	N	352	354
078	13	Total County Clerical Time	PAS SNE	3	N	355	357

PHRED PROJECT
DETAIL DESIGN DOCUMENTATION
I N P U T D E S C R I P T I O N

INPUT NAME
MEMS WELFARE OFFICE

INPUT ID

RECORD NAME
REFERRAL INFORMATION FORM (RIF)

RECORD NO. RECORD SIZE

FIELD NUMBER	DATA ELEMENT NUMBER	FIELD NAME	PROCEDURE INSTRUCTIONS	FIELD SIZE	DATA TYPE	POSITION FROM	POSITION THRU
079		(ID) Identification	RNFF	7	N	358	364
080		(IDF) Form Type	Enter Constant R	1	A	365	365
081	2	Medi-Cal Number	LJ If Not FF	14	N	366	379
082		(Name of Plan) "Code Plan contract number" XX (Coded in right margin)	PAS SNE	2	N	380	381
083	10	Date of First Contact (MMDDYY)		6	N	382	387
084	11	Method of Contact 1-Phone, 2-Mail, 3-Home 4-Walk-In	Punch Value Checked	1	N	388	388
085	12	Results of First Contact 1-Verified Enrollee, 2-Enrolled Other Plan, 3-No Contact, 4-Decision Pending, 5-Stay on Regular Medi-Cal 6-Other	Punch Value Checked	1	N	389	389
086	13	Number of Persons Enrolled (XX))	RJ	2	N	390	391
087	14	Does this represent the referral's total family 1-Yes, 2-No	Punch Value Checked	1	N	392	392
088	15	How many not enrolled (XX)	RJ	2	N	393	394
	NOTE:	DUE TO A FORM REVISION THE REST OF THE DOCUMENTS (ITEMS 16-19) WILL IN SOME CASES HAVE AN ADDITIONAL ITEM.					
089	16	Explain non-enrolling members, if any THIS ITEM WILL NOT BE PRESENT ON OLDER FORMS	PAS; If item not on the form ZNE	1	N	395	397
090	17	(Old 16, New 17) How many attempts were made before the individual was contacted XX	RJ P2	2	N	396	397

PHRED PROJECT
DETAIL DESIGN DOCUMENTATION
I N P U T D E S C R I P T I O N

INPUT NAME
MEMS WELFARE OFFICE

INPUT ID

RECORD NAME
REFERRAL INFORMATION FORM (RIF)

RECORD NO. RECORD SIZE

FIELD NUMBER	DATA ELEMENT NUMBER	FIELD NAME	PROCEDURE INSTRUCTIONS	FIELD SIZE	DATA TYPE	POSITION FROM	POSITION THRU
091	18	Date of Last Contact (MMDDYY)		6	N	398	403
092	19	Method of Contact (Old 18, New 19) 1-Phone, 2-Mail, 3-Home, 4-Walk-In	Punch Value Checked	1	N	404	404
093	20	Results of Last Contact (Old 19, New 20) 1-Verfied Enrollee 2-Enrolled Other Plan 3-No Contact 4-Decision Pending 5-Regular Medi-Cal 6-Advanced Enrollment	Punch Value Checked	1	N	405	405

PHRED PROJECT
DETAIL DESIGN DOCUMENTATION
I N P U T D E S C R I P T I O N

INPUT NAME
MEMS WELFARE OFFICE

INPUT ID

RECORD NAME
PHONE FOLLOW-UP INFORMATION FORM (PFIF)

RECORD NO. RECORD SIZE

FIELD NUMBER	DATA ELEMENT NUMBER	FIELD NAME	PROCEDURE INSTRUCTIONS	FIELD SIZE	DATA TYPE	POSITION FROM	POSITION THRU
094	ID	Identification	RNFF	7	N	406	412
095	IDF	Type of Form	F or Blank	1	A	413	413
096	IDN	Medi-Cal Number	LJ is not FF	14	N	414	427
097	1	Contact Method (1-4) 1-Mail, 2-At Home, 3-Social Service Office 4-Other	PAS SNE	1	N	428	428
098	2A	Want to join a PHP 1-Yes, 2-No	PAS SNE	1	N	429	429
099	2B	Stay on regular Medi-Cal 1-Yes, 2-No	PAS SNE	1	N	430	430
100	3	Agreement to Interview	PAS SNE	1	N	431	431
101	4	What did you think you had to do when you received the mailing	PAS SNE	1	N	432	432
102	5	Did mailing help you 1-Yes, 2-No, 3-Other	PAS SNE	1	N	433	433
103	6	Head of Household 1-Yes, 2-No	PAS SNE	1	N	434	434
104	7	How old are you	PAS SNE	2	N	435	436
105	8	Marital Status 1-Married, 2-Divorced 3-Single, 4-Separated 5-Widowed, 6-Other	PAS SNE	1	N	437	437
106	9	Highest Grade in School (XX 00-99)	RJ PZ	2	N	442	439
107	10	How many children	RJ PZ	2	N	440	441
108	11	Age of youngest child	RJ PZ	2	N	442	443
109	12	Age of oldest child	RJ PZ	2	N	444	445
110	13	Language spoken at home 1-English, 2-Spanish 3-Other	PAS SNE	1	N	446	446
111	14	Ethnicity 1-Asian, 2-Black, 3-Filipino, 4-Hispanic, 5-Native American, 6-White, 7-Other	PAS SNE	1	N	446	447

PHRED PROJECT
DETAIL DESIGN DOCUMENTATION
I N P U T D E S C R I P T I O N

INPUT NAME
MEMS WELFARE OFFICE

INPUT ID

RECORD NAME
PHONE FOLLOW-UP INFORMATION FORM (PFIF)

RECORD NO. RECORD SIZE

FIELD NUMBER	DATA ELEMENT NUMBER	FIELD NAME	PROCEDURE INSTRUCTIONS	FIELD SIZE	DATA TYPE	POSITION FROM	POSITION THRU
112	15	Do you have a family doctor right now 1-Yes, 2-No	PAS SNE	1	N	448	448
113	16	Satisfaction with current care 1-Very Satisfied 2-Satisified 3-So-So, 4-Dissatisifed 5-Very Dissatisfied	PAS SNE	1	N	449	449
114	17	How many times seen a doctor in the last year (00-99)	RJ PZ	2	N	450	451
115	18	How many times other members of the household seen a doctor in the last year (00-99)	RJ PZ	2	N	452	453
116	19	How many times hospitalized in the last year (00-99)	RJ PZ	2	N	454	455
117	20	How many times household members hospitalized in last year(00-99)	RJ PZ	2	N	456	457
118	21	Need medical care right now 1-Yes,2-No(PFIF CODES)	PAS SNE	1	N	458	458
*119	22	Heard of prepaid health plans before 1-Yes, 2-No.	PAS SNE	1	N	459	459
*120	23	You or anyone in your household joined a PHP before 1-Yes, 2-No, 3-Don't Know	PAS SNE	2	N	460	461
*121	24A	Main reason for joining a PHP (0-9)	PAS SNE	1	N	462	462
*122	24B	Services under one roof 1-Yes, 2-No, 3-Don't Know	PAS SNE	1	N	463	463

PHRED PROJECT
DETAIL DESIGN DOCUMENTATION
I N P U T D E S C R I P T I O N

INPUT NAME
MEMS WELFARE OFFICE

INPUT ID

RECORD NAME
PHONE FOLLOW-UP INFORMATION FORM (PFIF)

RECORD NO. RECORD SIZE

FIELD NUMBER	DATA ELEMENT NUMBER	FIELD NAME	PROCEDURE INSTRUCTIONS	FIELD SIZE	DATA TYPE	POSITION FROM	POSITION THRU
123	24C	Other reasons (0-9)	PAS SNE	1	N	464	464
124	24D	Stay on regular Medi-Cal (0-9)	PAS SNE	1	N	465	465
125	24E	Was it important to keep own doctor 1-Yes, 2-No, 3-Don't Know	PAS SNE	1	N	465	465
126	24F	Other important reasons (0-9)	PAS SNE	1	N	467	467
127	25A	What is the most important thing PHPs should do for you (0-9)	PAS SNE	1	N	468	468
128	25B	What is the most important thing that regular Medi-Cal should do for you (0-9)	PAS SNE	1	N	469	469
129	26	Has anyone from the health plan called or come by to see you to ask if you had questions about the services 1-Yes, Phone, 2-Yes, Home, 3-Yes, Other 4-Other	PAS SNE	1	N	470	470
130	27	Have you received a Plan booklet explaining the services 1-Yes, 2-No, 3-Don't Know	PAS SNE	1	N	471	471
131	28	Joining the PHP was completely voluntary and you don't have to enroll to keep your food stamps or aid 1-Yes, 2-No, 3-Don't Know	PAS SNE	1	N	472	472

PHRED PROJECT
DETAIL DESIGN DOCUMENTATION
I N P U T D E S C R I P T I O N

INPUT NAME
MEMS WELFARE OFFICE

INPUT ID

RECORD NAME
PHONE FOLLOW-UP INFORMATION FORM (PFIF)

RECORD NO. RECORD SIZE

FIELD NUMBER	DATA ELEMENT NUMBER	FIELD NAME	PROCEDURE INSTRUCTIONS	FIELD SIZE	DATA TYPE	POSITION FROM	POSITION THRU
132	29A	After 30 days you can disenroll (get out) for any reason 1-Yes, 2-No, 3-Don't Know	PAS SNE	1	N	473	473
133	29B	After 30 days you can disenroll if you are dissatisfied after you use the Plan grievance system 1-Yes, 2-No, 3-Don't Know	PAS SNE	1	N	474	474
134	30	Did anyone check to see if you were under a doctor's care 1-Yes, 2-No, 3-Don't Know	PAS SNE	1	N	475	475
135	31	After your enrollment begins you can't go to your current doctor unless he/she is on the list 1-Yes, 2-No, 3-Don't Know	PAS SNE	1	N	476	476
136	32	Until then do you know how to get health care 1-Yes, 2-No, 3-Don't Know	PAS SNE	1	N	477	477
137	33	Prepaid health plans part of Medi-Cal 1-Yes, 2-False, 3-Don't Know	PAS SNE	1	N	478	478
138	34	Regular Medi-Cal and prepaid Medi-Cal provide basic health care at no cost to you 1-Yes, 2-False 3-Don't Know	PAS SNE	1	N	479	479

PHRED PROJECT
DETAIL DESIGN DOCUMENTATION
I N P U T D E S C R I P T I O N

INPUT NAME
MEMS WELFARE OFFICE

INPUT ID

RECORD NAME
PHONE FOLLOW-UP INFORMATION FORM (PFIF)

RECORD NO. RECORD SIZE

FIELD NUMBER	DATA ELEMENT NUMBER	FIELD NAME	PROCEDURE INSTRUCTIONS	FIELD SIZE	DATA TYPE	POSITION FROM	POSITION THRU
139	35	People eligible for Medi-Cal may choose between regular Medi-Cal and prepaid Medi-Cal 1-Yes, 2-False, 3-Don't Know	PAS SNE	1	N	480	480
140	36	PHPs offer extra services that regular Medi-Cal doesn't 1-Yes, 2-False, 3-Don't Know	PAS SNE	1	N	481	481
141	37	People who use regular Medi-Cal have to use the same doctor all the time 1-Yes, 2-False, 3-Don't Know	PAS SNE	1	N	482	482
142	38	Prepaid Medi-Cal you must go to that Plans facilities except in emergencies when you can't get there 1-Yes, 2-False, 3-Don't Know	PAS SNE	1	N	483	483
143	39	People on Medi-Cal who go to PHPs are guaranteed health care by the Plan 1-Yes, 2-False, 3-Don't Know	PAS SNE	1	N	484	484
144	40	PHPs allow their members to go anywhere they want for health care 1-Yes, 2-False, 3-Don't Know	PAS SNE	1	N	485	485

PHRED PROJECT
DETAIL DESIGN DOCUMENTATION
I N P U T D E S C R I P T I O N

INPUT NAME
MEMS WELFARE OFFICE

INPUT ID

RECORD NAME
PHONE FOLLOW-UP INFORMATION FORM (PFIF)

RECORD NO. RECORD SIZE

FIELD NUMBER	DATA ELEMENT NUMBER	FIELD NAME	PROCEDURE INSTRUCTIONS	FIELD SIZE	DATA TYPE	POSITION FROM	POSITION THRU
145	41	People using regular Medi-Cal must find their own doctor 1-Yes, 2-False, 3-Don't Know	PAS SNE	1	N	486	486
146	42	It may take approximately 60 days to disenroll from a prepaid health plan 1-Yes, 2-False, 3-Don't Know	PAS SNE	1	N	487	487
147	43	Correct Address 1-Yes, 2-No	PAS SNE	1	N	488	488
148	44	Interviewer (XX) 1-Marguerite, 2-Suzanne, 3-Bob, 4-Kathy, 5-Anthony 6-Tom, 7-Jo, 8-Other	RJ PZ	2	N	489	490
149	45	Date of Interview (YYDDD - JULIAN)	PAS SNE	5	N	491	495
150	46	Clock time of interview	PAS SNE	4	N	496	499
151	47	Number of Tries (XX - 01-99)	RJ PZ	2	N	500	501
152	48	Interview Time (In Minutes)	RJ PZ	2	N	502	503

* CODE 9999 - Mailed Out Forms

II. Mail Method

Mail Method (M)--This method solicited enrollment through the use of information packages and choice cards mailed to eligible beneficiaries. Forms used for this method included:

Choice Card--card returned by the beneficiary indicating health care choice (fee-for-service or prepaid Medi-Cal--enrollment or information).

Mail Information Form (MIF)--identification and contact document sent to plans to refer and collect results data for persons enrolling or showing interest in enrolling as a result of receiving a mail information package.

Phone Follow-Up Information Form (PFIF)*--demographic, comprehension, and retention information, and attitudes about Medi-Cal and health care.

*This instrument was the same for all the major methods.

Please take a few minutes to answer these questions:

1. Do you have a regular source of health care?
   1) ☐ Yes 2) ☐ No
2. If you or a member of your household is sick, where do you usually go for care?
   1) ☐ Private doctor 2) ☐ County clinic
   3) ☐ County hospital 4) ☐ Emergency room
   5) ☐ Other
3. Do you or a member of your household need medical care now? 1) ☐ Yes 2) ☐ No
4. Had you ever heard of Health Maintenance Organizations (HMOs) before you received this?
   1) ☐ Yes 2) ☐ No
5. Have you or a member of your family ever joined an HMO? 1) ☐ Yes 2) ☐ No

Mail back to State Dept. of Health Services — No stamp necessary.

(Vease el otro lado para la version en espanol)

- Please tell us what you have decided about your health care by marking:
  - Box A — Enroll me and my family in an HMO.
  - Box B — I'd like to learn more about HMOs, but keep my sticker card for now.
  - Box C — I'd like to keep my monthly sticker card.
- If you have chosen an HMO, check the box by the plan's name below and tell us how you want to be contacted.
  - ☐ Home Visit ☐ Telephone Call
  - ☐ Contra Costa Key Plan

Here is the choice: (Please give information below for each family member, including yourself.)

Name Last First Middle	Relationship to You?	Sex	Birthday Mo /Day/ Yr	A Enroll in An HMO	B Learn More About HMOs	C Monthly Sticker Card
	(self)					

Print Name	Sign	Date	Phone

Por favor tómese unos minutos para contestar estas preguntas:

1. ¿Tiene usted un médico de recibir cuidados para la salud regularmente? 1) ☐ Sí 2) ☐ No
2. ¿Si usted o una persona de su casa se enferma, a dónde va, generalmente, por atención médica?
   1) Médico privado 2) Clínica del condado
   3) Hospital del condado 4) Servicio de emergencia 5) otro
3. ¿Usted o una persona de su casa necesita cuidados médicos ahora? 1) ☐ Sí 2) ☐ No
4. ¿Sabía ya de las Organizaciones para el Mantenimiento de la Salud (HMOs) antes de haber recibido ésta? 1) ☐ Sí 2) ☐ No
5. ¿Nunca ha ingresado, usted o un miembro de su familia, a un HMO? 1) ☐ Sí 2) ☐ No

---

- Por favor díganos que ha decidido acerca de los cuidados para su salud, marcando:
  - Cuadro A — Enrolen a mi familia y a mí en un HMO.
  - Cuadro B — Deseo tener más información acerca de un HMO. Por ahora me quedaré con mi tarjeta con etiquetas.
  - Cuadro C — Deseo quedarme con mi tarjeta con etiquetas mensualmente.

- Si usted ha escogido un HMO, marque el cuadro con el nombre del plan y díganos cómo comunicarnos con usted.

☐ ¿Visita en su casa? ☐ ¿Llamada telefónica?

☐ "Rockridge" Plan de Ciudados para la Salud

Regrésela al Departamento de Servicios de Salud del Estado — No necesita estampilla.

Esto es lo que escogí: (Por favor dé la información correspondiente por cada miembro de la familia, incluyendose usted mismo)

Nombre Apellido, Primero, Segundo	¿Qué Relación a Ud ?	Sexo	Fecha de Nacimiento Mes/Día/Año	A Enrolme en un HMO	B Deseo más información	C Guardaré mi tarjeta

Nombre:_____
(letra de imprenta) Dirección Ciudad Zona Postal Teléfono

Firma:_____ Fecha:_____ Número de Medi-Cal._____

(Favor de copiar los números en el lado izquierdo de su tarjeta, hasta las estrellitas**)

MAIL INFORMATION FORM (MIF)

PHRED USE ONLY

1. Referral Number: ☐☐ ☐☐☐☐☐☐☐☐

2. Date received by PHRED: ☐☐☐☐☐☐
(month, day, year)

3. Date mailed to plan: ☐☐☐☐☐☐
(month, day, year)

Name of Plan _____

22. Date MIF returned to PHRED: ☐☐☐☐☐☐

23. Follow-up needed? 1) ☐ Yes 2) ☐ No
If yes, describe: _____

24. Results of follow up satisfactory?
1) ☐ Yes 2) ☐ No 3) ☐ Not Applicable
If no, describe: _____

PLAN USE BELOW THIS LINE

4. Referral's Name: (last, first, middle)
☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

5. Referral's Medi-Cal Number: ☐☐☐☐☐☐☐☐☐☐

6. Referral's Address: (house number, street or road)
☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐
☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

7. (Zip) ☐☐☐☐☐

8. Referral's Phone Number: ☐☐☐ ☐☐☐ ☐☐☐☐

TO THE PLAN: If contact was not referred to you by PHRED, please fill in Items 4 -8 and indicate how referral was made:

9. 1) ☐ Self, result of mailer 2) ☐ Other: _____

The person named on this form has indicated an interest in:

10A. 1) ☐ Enrolling in 2) ☐ Learning about your plan.

Please contact this person within:

10B. _____ days.

11. 1) ☐ By phone 2) ☐ At home

12. Return this form to PHRED by: ☐☐☐☐☐☐ (mo., day, year)

13. How many times was the individual contacted? ☐☐ (enter number)

DESCRIBE THE FIRST CONTACT:

14. Date: ☐☐☐☐☐☐ (month, day, year)

15. Method of contact: 1) ☐ Phone 2) ☐ Mail
3) ☐ Home 4) ☐

16. Results of first contact:
1) ☐ Verified enrollee 2) ☐ Enrolled other plan
3) ☐ No contact 4) ☐ Decision pending
5) ☐ Stay on regular Medi-Cal 6) ☐ Advance enrollment
7) ☐ Other: _____

IF MORE THAN ONE CONTACT, DESCRIBE THE LAST:

17. Date: ☐☐☐☐☐☐ (month, day, year)

18. Method of contact: 1) ☐ Phone 2) ☐ Mail
3) ☐ Home 4) ☐ Walk-in

19. Results of last contact:
1) ☐ Verified enrollee 2) ☐ Enrolled other plan
3) ☐ No contact 4) ☐ Decision pending
5) ☐ Stay on regular Medi-Cal 6) ☐ Advance enrollment
7) ☐ Other: _____

20 How many persons enrolled? ☐☐ (enter number)

21. Does this represent the referral's total family?
1) ☐ Yes 2) ☐ No (WHY NOT? _____

I-59

State of California—Health and Welfare Agency

Department of Health Services

F

PHONE FOLLOW–UP INFORMATION FORM (PFIF)

I
Completed ☐
Follow-Up ☐
II
Mailer ☐
Current ☐
In-Office ☐
III
Enrolled ☐
Not Enrolled ☐

(To be used to collect demographic, choice factor, comprehension, and verification data)

INSTRUCTIONS TO THE INTERVIEWER: Fill in as much information as possible before the contact. When using the probe/comment response, circle the appropriate category and write in phrase/question. Make sure that the proper sections are completed for each individual.

Medi-Cal Number _____ Phone ____-____-____

SECTION I – ALL PERSONS

Hello, is this Mrs./Ms./Mr. _____? My name is _____, I am with the Department of Health Services.

1. Recently you were contacted: ☐ 1) by mail ☐ 2) at home ☐ 3) at the Social Service office ☐ 4) Other _____ about joining a pre-paid health plan. You were asked to choose between a PHP and your regular Medi-Cal card. *Probe/Comment* _____ 1. _____

2. I have down here that you want to:
   ☐ A) Join a/ _____ PHP with _____ Other members of your family.
   Is this correct?
   ☐ 1) Yes, continue
   ☐ 2) No, *Probe/Comment* _____ 2A. _____

   ☐ B) Stay with regular Medi-Cal. Is this correct?
   ☐ 3) Yes, continue
   ☐ 4) No, *Probe/Comment* _____ 2B. _____

I would really appreciate it if you would take a few minutes and discuss your decision with me. The Department of Health Services is very interested in improving how health care is provided to you. One important way that we can do that is by getting your opinions.

3. Is this all right with you?
   ☐ 1) Yes, continue
   ☐ No, then *Probe: Is there some other time that I could call back that would be more convenient for you?*
   ☐ 2) Yes, take time and date: _____
   ☐ 3) No, thank respondent for time and say good-bye. 3. _____

SECTION II – MAIL RESPONDENTS ONLY

First, Mrs./Ms./Mr. _____, I'd like to ask you two questions about the mail packet that you received from the department.

4. What did you think you had to do when you got the mailing?
   ☐ 1) Enroll in a plan. ☐ 2) Get more information
   ☐ 3) Send back card to stay on Medi-Cal ☐ 4) Nothing ☐ 5) Other 4. _____

5. Did the mailing help you?
   ☐ 1) Yes, *Comment:* _____
   ☐ 2) No, *Comment:* _____
   ☐ 3) Other, *Comment:* _____ 5. _____

SECTION III DEMOGRAPHICS – MAIL, CURRENT METHOD ONLY

Now, Mrs. / Ms. / Mr. _____, I'd like to ask you some general questions about you and your family.

6. Are you the head of the household?
   ☐ 1) Yes – ask questions in "YOU" format
   ☐ 2) No – ask questions in "HEAD OF HOUSEHOLD" format and
   PROBE: Who is? _____ | 6. _____

7. How old are you/head of household? _____ years | 7. _____

8. What is your/head of household's marital status?
   ☐ 1) married ☐ 2) divorced ☐ 3) single ☐ 4) separated ☐ 5) widowed ☐ 6) other | 8. _____

9. What was your/head of household's highest grade completed in school? _____ years | 9. |__|__|

10. How many children are in the household? |__|__| children | 10. |__|__|

11. How old is the youngest child? |__|__| years | 11. |__|__|

12. How old is the oldest child? |__|__| years | 12. |__|__|

13. What language is spoken in your home? ☐ 1) English ☐ 2) Spanish ☐ 3) Other: _____ | 13. _____

14. What would you say is your ethnic background?
   ☐ 1) Asian ☐ 2) Black ☐ 3) Filipino ☐ 4) Hispanic
   ☐ 5) Native American ☐ 6) White ☐ 7) Other_____ | 14. _____

SECTION IV. A CHOICE FACTORS – HEALTH, ALL PERSONS

Next, Mrs. / Ms. / Mr. _____, I'd like to ask you about you and your family's health.

15. Do you have a family doctor right now?
   ☐ 1) Yes
   ☐ 2) No, then *PROBE: Where to you get most of your care right now?* _____ | 15. _____

16. How satisfied are you with the care you are receiving from _____ ? Would you say you are:
   ☐ 1) Very Satisfied ☐ 2) Satisfied ☐ 3) So-So ☐ 4) Dissatisfied ☐ 5) Very Dissatisfied
   Comment: _____ | 16. _____

17. How many times have you/head of household seen a doctor in the last year? _____ times | 17. |__|__|

18. How many times have other members of the household seen a doctor in the last year? _____ times | 18. |__|__|

19. How many times have you/head of household been hospitalized in the last year? _____ times | 19. |__|__|

20. How many times have other members of your household been hospitalized in the last year? _____ times | 20. |__|__|

21. Do you or any members of your household need medical care right now?
   ☐ 1) Yes ☐ 2) No *Probe/Comment:* _____ | 21. _____

SECTION IV.B CHOICE FACTORS – DECISION, ALL PERSONS

xt set of questions is about your decision to:
☐ Join a PHP ☐ Stay with regular Medi-Cal

22. Had you ever heard of pre-paid health plans before you were contacted?
☐ 1) Yes ☐ 2) No *Probe/Comment:* _____ 22. _____

23. Have you or anyone in your household ever joined a PHP before?
☐ 1) Yes ☐ 2) No *Probe/Comment:* _____ 23. _____

24. What would you say is the main reason why you decided to: 24.
A ☐ Join a PHP? _____ A _____
B *PROBE: Was it important to you that all of the services were under one roof?*
☐ 1) Yes ☐ 2) No _____ B _____
C *PROBE: What other reasons were important to you?* _____ C _____
D ☐ Stay with regular Medi-Cal? _____ D _____
E *PROBE: Was it important to you to choose your own doctor?*
☐ 1) Yes ☐ 2) No _____ E _____
F *PROBE: What other reasons were important to you?* _____
_____ F _____

25. What would you say is the most important thing that 25.
A ☐ PHPS should do for you? _____ A _____
B ☐ Regular Medi-Cal should do for you? _____ B _____

SECTION V VERIFICATION – ENROLLEES ONLY

d like to check with you on some things that have or will be happening with your enrollment.

26. Has anyone from the health plan called or come to see you to ask if you have any questions about services?
A. Yes ☐ 1) Phone verification ☐ 2) Home verification ☐ 3) Other _____
B. No ☐ 4) 26. _____

27. Have you received a plan booklet explaining the services available?
☐ 1) Yes ☐ 2) No *Comment:* _____ 27. _____

28. Do you understand that joining the plan was completely voluntary and that you don't have to enroll to keep your food stamps or aid?
☐ 1) Yes ☐ 2) No *Comment:* _____ 28. _____

29A. Do you understand that during the first 30 days of membership you can disenroll (get out) for any reason? 29.
☐ 1) Yes ☐ 2) No *Comment:* _____ A _____

29B. Do you understand that after the first 30 days you can disenroll if you are dissatisfied after you use the plan's grievance system.
☐ 1) Yes ☐ 2) No *Comment:* _____ B _____

30. Did anyone check to see if you were under a doctor's care?
☐ 1) Yes ☐ 2) No *Comment:* _____ 30. _____

31. Do you understand that after your enrollment begins you can't to back to your current doctor unless he or she is on the list?
☐ 1) Yes ☐ 2) No *Comment:* _____ 31. _____

32. Your enrollment will probably be effective _____, you will know because you won't get your Medi-Cal card and the plan will send you an ID card instead. Until then, do you know how to get health care?
☐ 1) Yes ☐ 2) No *Advise:* _____ 32. _____

SECTION VI COMPREHENSION QUESTIONS – ALL RESPONDENTS

The last thing I'd like to do is see how well *WE* presented information about health care to you by asking you some questions about PHPs and regular Medi-Cal. Just answer TRUE if you think the question is true, or FALSE if you think the question is false: *Probe/Comment:* _____

Code 1 = Yes 2 = No

33.	T	F	Pre-paid health plans are part of Medi-Cal.	33. _____
34.	T	F	Both regular Medi-Cal and pre-paid Medi-Cal provide basic health care at no cost to you.	34. _____
35.	T	F	People who are eligible for Medi-Cal may choose between regular Medi-Cal and pre-paid Medi-Cal.	35. _____
36.	T	F	Sometimes PHPs offer extra services that regular Medi-Cal doesn't.	36. _____
37.	T	F	People who use regular Medi-Cal have to use the same doctor all the time.	37. _____
38.	T	F	If you are using pre-paid Medi-Cal, you must go to that plan's facilities except in emergencies when you can't get there.	38. _____
39.	T	F	People on Medi-Cal who go to PHPs are guaranteed health care by the plan.	39. _____
40.	T	F	PHPs allow their members to go anywhere they want for health care.	40. _____
41.	T	F	People using regular Medi-Cal must find their own doctors.	41. _____
42.	T	F	It may take approximately 60 days to disenroll from a pre-paid health plan.	42. _____

Thank you very much Mrs. / Ms. / Mr. _____, for your time and cooperation.

You've been bery helpful. Just one more thing before I go, I'd like to check and see if I have your correct address. Is it still _____

_____

43. ☐ 1) Yes
☐ 2) No, get correct address. 43. _____

COMMENTS:

_____

_____

_____

_____

44. INTERVIEWER: _____ 44. |_|_|

45. DATE: _____ 45. |_|_|_|_|

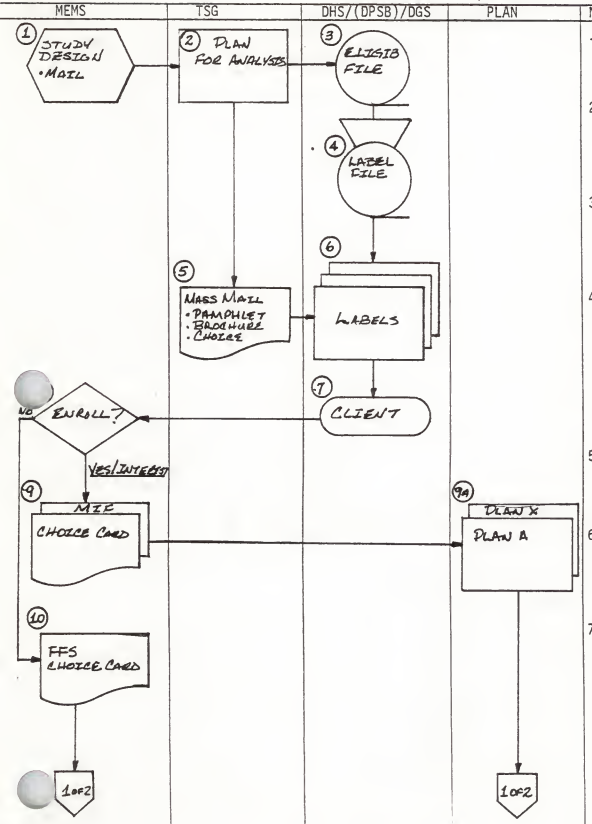
46. TIME: _____ 46. |_|_|_|_|

47. Number of Tries: _____ 47. |_|_| |_|_|

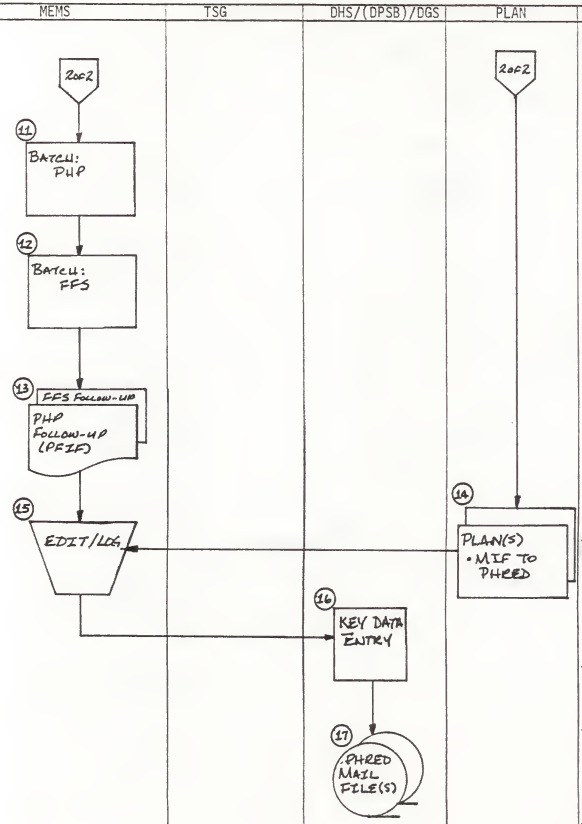
48. Amount of Interview Time: _____ 48. |_|_| |_|_| Minutes

MAILING

SEQUENCE/DOCUMENT FLOW/CONTROL/RESPONSIBILITIES


MEMS
TSG
DHS/(DPSB)/DGS
PLAN
NARRATIVE
1 STUDY DESIGN • MAIL
2 PLAN FOR ANALYSIS
3 ELIGIB FILE
4 LABEL FILE
5 MASS MAIL • PAMPHLET • BROCHURE • CHOICE
6 LABELS
7 CLIENT
ENROLL?
NO
YES/INTERST
9 MIS CHOICE CARD
9A PLAN X PLAN A
10 FFS CHOICE CARD
1 OF 2
1 OF 2
1) Study design and series of questions to be answered.
2) Plan for analysis developed.
• output definitions
• process flow
• data collection
3) DPSB extracts from eligibility all persons in zip codes required with PHP eligible aid codes.
4) Label tape produces labels and listings which includes (8 different mailings)
• counts of aid codes by zip
• alpha within zip
• each label has a sequence number.
5) Mailing package include enclosures & choice card. Label is affixed and mailed.
6) Labels are produced and attached to mass mail card by Department of General Services.
7) Mail goes to clients in designated areas. client returns card to DHS with choice indicated.
• enroll
• not enroll
• interest

MAILING
SEQUENCE/DOCUMENT FLOW/CONTROL/RESPONSIBILITIES



8) Sort-MEMS Clerk sorts cards into two groups.
   (1) requesting Plan
   (2) stay on FFS Medi-Cal
   (3) counts on the Daily Aggregate
   - heads of households choosing
   - number of heads of households
   - number being chosen for
   - number undelivered, moved, missing label
   - number choosing to stay on FFS

9) Process-Route-MEMS Clerk
   - if enroll photocopy MIF and choice card, send original to Plan
   - stamp batch and sequence number on Project copies

9A) Route -MEMS Clerk
   - choice & MIF to plan

10) FFS Choice Cards

   - if necessary fill in Medi-Cal number
   - file by batch and date

11) Batch-PHP
   - batch MIF
   - batch cover

12) Batch-FFS
   - sample
   - photocopy choice card
   - stamp
   - stamp & schedule PFIF

13) Phone Follow-Up
   - 2-4 weeks phone follow-up completed

14) Plan returns MIF to PHRED

MAILING
SEQUENCE/DOCUMENT FLOW/CONTROL/RESPONSIBILITIES

MEMS	TSG	DHS/(DPSB)/DGS	PLAN	NARRATIVE
				15) Edit • MIF's returning • Plan call-backs (as needed) • check off batch cover sheet • completeness and logic errors • send batch to KDE • log out and in 16) Key enter MIF and FFS follow-up and PHP follow-up. 17) Output files: PHRED mail file.

FORM CYCLE--MIF
(Routing, Batching and Logging)

	ACTION	RESPONSIBLE PARTY	NARRATIVE
1.	Request	MEMS clerk to TSG to MEMS clerk	A request for labels (including applicable zip and aid codes) is prepared by MEMS and sent to TSG. Two weeks of lead time is required to generate labels. Once these have been printed they will be returned to MEMS.
2.	Route	Mems clerk to Mass Mail	Form distribution and printing requests are handled by MEMS. MEMS will be responsible for scheduling the number of forms needed for mailings and insuring Mass Mailing has sufficient material to do the job.
3.	Sort	MEMS clerk	MEMS clerk will sort cards into two groups: (1) those requesting plan, (2) those wishing to stay on regular Medi-Cal (note: if the choice is not clear and a phone number is on card, the beneficiary should be called). Those cards and/or material returned should be sorted into the categories-undelivered, moved, missing label. These should be counted and totaled and entered in the Daily Aggregate (see form attached).
4.	Count	MEMS clerk	A daily count total must be kept on the Daily Aggregate by batch and date of returned cards. Totals should be kept on a daily basis and more than one day's total can be kept on a page. Totals include the following: (1) number of people the head of household is choosing for, number being chosen for including head of household, (3) number returned undeliverable, number moved, and missing labels, (4) number choosing to stay on regular Medi-Cal. Separate totals for this last category of those choosing to stay on regular Medi-Cal, but want plan information and those who are staying and want no information. The final column is for total returns for the day. All choice cards that are returned complete, excluding those undeliverable, should be checked for completeness, batched and dated. Completed forms (i.e., items 1-5 and family information) should be separated from incomplete forms. The former will be used as a population for telephone follow-ups.

	ACTION	RESPONSIBLE PARTY	NARRATIVE
5.	Process	MEMS clerk	For persons requesting enrollment or wishing to learn about the plan, the MEMS clerk will initiate a Mail Information Form (MIF). Items 1-8 and 8-12 will be completed and forwarded to the plan(s). The MEMS clerk stamps date, batch and sequence numbers on outgoing MIFs for control purposes.
6.	Route	MEMS clerk to plan	MIFs will be sent to the plan as soon as possible. A copy of the MIF should be kept at PHRED for control and reference. If forms are returned in a physical condition which makes them unreadable, the most readable form should be used. If the respondent requests enrollment, the choice card will be xeroxed by the MC with the original going to the plan and the copy staying with PHRED. If the individual seeks information on more than one plan, MIFs will be sent to each with original staying at PHRED. Care must be taken to use the same ID number on each MIF sent out for the same individual. A prelabeled envelope for sending documents to plans should be available.
7A.	Batch PHP	MEMS clerk	The MEMS clerk batches MIFs for PHP choices. The MIF used should be the one which is most readable. On the Batch Cover Sheet the sequence number is entered. The method is checked and batch type is checked. The date for the return of the MIF and when the PFIF should be scheduled.
7B.	Batch PHP	MEMS clerk	When the limit (99) of the batch sequence number has been reached either by volume or the end of the day's returns, MIF and Choice Card copies are assembled together and the batch control number entered on the Batch Cover Sheet. Both PHP and FFS batches may be entered on the same Batch Log Sheet.
8.	Batch FFS	MEMS clerk	For those returning cards indicating a wish to stay on regular Medi-Cal, the MC will file the cards on a daily basis. Extracting those which are to be included in the sample. Those will be photocopied, stamped and batched as in the case of person choosing PHP. (See General Specs for Mail Sample).

	ACTION	RESPONSIBLE PARTY	NARRATIVE
9.	Phone Follow-Up	MEMS clerk and/ or Field Representative	From two to four weeks after a Choice Card has been returned to PHRED, a PFIF should be done. All of those selecting PHPs and a 20 percent sample of those choosing to remain on FFS will be contacted.* The FFS sample should be drawn from the returning cards. The label batch number should be entered and right justified in the blanks provided on the upper right-hand corner of the PFIF. (See General Specifications for sampling).
10A	Edit	MEMS clerk	As completed MIFs are sent back to PHRED from the plans, the MC will check this off on the Batch Cover Sheet. If forms are not returned within 30 days as indicated on the Batch Cover Sheet, the MC will contact the Plans and inquire about them. A date should be agreed upon and this entered on the Batch Cover Sheet.
10B	Edit	MEMS clerk	The returning MIFs should be edited for completeness and logical contradictions. If clarification is needed, the plan must be called.
11.	Route	MEMS clerk to KDE via TSG	When all documents have been returned (MIF returned and PFIF on PHP and FFS sample), a batch is ready for submission to KDE. The MC should forward the completed batches to the TSG on a flow basis for key data entry.

*If backlogs develop, completed Choice Cards will be treated as the sample with the requirement being to contact as many FFS choosers up to a specified amount based on the number of total mail returns.

Instructional Guide
MAIL INFORMATION FORM

This document will be completed by PHRED/PLAN staff for every person from the mailing demonstration who wishes more information about and/or enrollment in a PHP.

The following account is an item-by-item description of the data needed for each question on the MIF. Responsibilities for each item are indicated within parentheses.

1. REFERRAL NUMBER - (PHRED) PHRED staff will indicate the log number given to each individual from the listing of preprinted labels. The first two digits will be the code number for the particular Plan being contacted.

2. DATE RECEIVED BY PHRED - (PHRED) PHRED staff will indicate the date the mailer card was delivered to the PHRED Project in the following order - month, day, year. Example - March 20, 1979 would be |0|3|2|0|7|9|.

3. DATE MAILED TO PLAN - (PHRED) PHRED staff will indicate the date the mailer card was sent to the Plan in the following order - month, day, year. Example - March 23, 1979 would be |0|3|2|3|7|9|.

4. REFERRAL NAME - (PHRED/PLAN) PHRED staff will indicate the respondent's name if referring the individual to the Plan; the Plan will indicate the respondent's name if individual is self-referred. The name should be printed in the following order - last, first, middle with a space skipped between last and first and between first and middle.

5. REFERRAL'S MEDI-CAL NUMBER - (PHRED/PLAN) PHRED staff will indicate the respondent's Medi-Cal number if referring the individual to the Plan; Plan will indicate the respondent's Medi-Cal number if individual is self-referred.

6-7. REFERRAL'S ADDRESS - (PHRED/PLAN) PHRED staff will indicate the respondent's address if referring individual to the Plan; Plan will indicate the respondent's address if individual is self-referred. The address should be filled in as follows:

   A. The respondent's house number followed by street or road with one space skipped between number and street. If respondent resides in an apartment, apartment number should be entered after street with one space skipped in between.

   B. Enter the name of the city in which the respondent lives.

   C. Enter the name of the county in which the respondent lives.

   D. Enter the respondent's zip code.

8. REFERRAL'S PHONE NUMBER - (PHRED/PLAN) PHRED staff will indicate the respondent's phone number if referring the individual to the Plan. Plan will indicate the respondent's phone number if individual is

self-referred. Phone number should be entered in the following order - area code (3 digits), prefix (3 digits), number (4 digits).

9. OTHER REFERRAL - (PLAN) The Plan will indicate how the respondent was referred, if not done by PHRED. 1=self referred as a result of the mailer, 2=other (please specify).

10A. TYPE OF INTEREST - (PHRED) PHRED staff will indicate the type of interest the respondent has identified - 1=enrollment or 2=learning about.

10B. NUMBER OF DAYS TO CONTACT - (PHRED) PHRED staff will indicate the desired number of days the Plan has to contact the respondent.

11. METHOD OF CONTACT DESIRED - (PHRED) PHRED staff will indicate the method by which the respondent wishes to be contacted by the Plan - 1=phone call, 2=home visit, or 3=mail.

12. RETURN FORM TO PHRED BY - (PHRED) PHRED staff will indicate the date the MIF should be returned by the Plan in the following order: month, day, year.

13. NUMBER OF TIMES CONTACTED - (PLAN) The Plan should indicate the total times the individual was contacted. Example - 4 visits would be |0|4|. (See General Specifications for definition of a contact.)

14. DATE OF FIRST CONTACT - (PLAN) The Plan should indicate the date of their first contact with the individual in the following order - month, day, year. Example - April 5, 1979 would be |0|4|0|5|7|9|.

15. METHOD OF FIRST CONTACT - (PLAN) The Plan should indicate the method of their first contact with the individual with - 1=phone call, 2=mailed material, 3=home visit, 4=walk-in (respondent walks into Plan on own).

16. RESULTS OF FIRST CONTACT - (PHRED/PLAN) The Plan should indicate the results of their first contact with the individual with - 1=verified enrollee, 2=enrolled in another Plan, 3=no contact made, 4=decision pending, 5=stay on regular Medi-Cal, 6=advance enrollment.

    Advanced enrollment will be marked on the NIF by PHRED before referred to the Plan to indicate that the beneficiary has enrolled by mail pending only verifications and orientation.

NOTE: IF THERE WAS MORE THAN ONE CONTACT, THE PLAN SHOULD FILL IN ITEMS 17-19. IF NOT, THESE ITEMS SHOULD BE LEFT BLANK. BE SURE NOT TO MARK THE RESPONDENT AS ENROLLING ON BOTH CONTACTS.

17. DATE OF LAST CONTACT - (PLAN) The Plan should indicate the date of their last contact with the individual in the following order - month, day, year. Example - April 10, 1979 would be |0|4|1|0|7|9|.

18. METHOD OF LAST CONTACT - (PLAN) The Plan should indicate the method used on their last contact with the individual with - 1=phone call, 2=mailed

material, 3=home visit, 4=walk-in (respondent walks into Plan, self-referred).

19. RESULTS OF LAST CONTACT - (PLAN/PHRED) The Plan should indicate the results of their last contact with the individual with - 1=verified enrollee, 2=enrolled in another Plan, 3=no contact made, 4=decision pending, 5=stay on regular Medi-Cal, 6=advance enrollment.

    Advanced enrollment will be marked on the NIF by PHRED before referred to the Plan to indicate that the beneficiary has enrolled by mail pending only verifications and orientation.

NOTE: BE SURE NOT TO MARK THE RESPONDENT AS ENROLLING ON BOTH CONTACTS.

20. NUMBER OF PERSONS ENROLLED - (PLAN) The Plan should indicate the number of persons enrolled as a direct result of this referral. IF NO PERSONS ENROLL, MARK |0|0|. In other cases, indicate the exact number, Example - 6 persons would be |0|6|.

21. REPRESENT ENTIRE FAMILY - (PLAN) The Plan should indicate whether or not the number of persons enrolled represents the respondent's entire family. IF NO ONE ENROLLED, MARK NOT APPLICABLE. 1=Yes, 2=No, 3=Not Applicable.

22. DATE MIF RETURNED TO PHRED - (PHRED) PHRED staff should indicate the date the MIF was received by them in the following order - month, day, year.

23. FOLLOW-UP NEEDED - (PHRED) PHRED staff should indicate whether or not a follow-up is needed on the individual to ensure proper coding of data or completeness of data. Code: 1=Yes, 2=No. If yes, describe the problem and indicate who should be contacted.

24. FOLLOW-UP SATISFACTORY - (PHRED) PHRED staff should indicate whether or not the results of the follow-up were satisfactory (problem solved). Code: 1=Yes, 2=No, and 3=Not Applicable. If no, describe why not.

KDE SUBMISSION REQUIREMENTS

1. Batch/sequence number should be clear and unambigious at the upper right hand corner of the top form.

2. The form type must follow the number. On some forms they are pre-printed. If the form you are using is not, code as necessary --

   BIF = B
   CAPIF = C
   RIF = R
   MIF = M
   PFIF = F
   PRF = P

3. Before submission check on all forms to ensure that the forms are readable and the numbers are clearly visible. This includes items that the client has filled out as well as that which PHRED staff has filled out.

4. Special codes on the CAPIF, #7-10, and PFIF items #15, 22, 23, 24A, 24B, 24C, 24D, 24E, 24F, 25A, and 25B have been coded.

5. Blank items should be left blank.

Order - W.O.

1. Batch Cover Sheet
2. Basic Information Form
3. Choice and Presentation Information Form
4. Referral Information Form
5. Presentation Information Form

C

1. Batch Cover Sheet
2. Presentation Results Form
3. Phone Follow-Up Information Form

Mail

1. Batch Cover Sheet
2. Mail Information Form
3. Phone Follow-Up Information Form

PHRED PROJECT
DETAIL DESIGN DOCUMENTATION
INPUT DESCRIPTION

INPUT NAME
MEMBERSHIP STUDIES-MARKETING ENROLLMENT

INPUT ID
HSA00-54

RECORD NAME
MEMS MAIL CHOICE ONLY

RECORD NO. RECORD SIZE
122

FIELD NUMBER	DATA ELEMENT NUMBER	FIELD NAME	PROCEDURE INSTRUCTIONS	FIELD SIZE	DATA TYPE	POSITION FROM	POSITION THRU
001	ID	Identification	RNFF	6	AN	1	6
002	IDF	Form Type Enter CO for all forms of this type	CO or b	2	A	7	8
003	IDN	Name Enter as shown (first line of label only) space between | | ∅ | | ∅ | |	PAS SNE	30	A	9	38
004	1	Do you have a regular source of health care	PAS SNE	1	N	39	39
005	2	If you or a member of household is sick where to you usually go for care 1-Private Doctor 2-County Clinic 3-County Hospital 4-Emergency Room 5-Other	PAS SNE	1	N	40	40
006		(Decide)Please tell us what you have decided about your health care by marking A-Enroll, B-HMO, but sticker, C-Sticker	Enter item circle, if not SNE	1	A	41	41
007	3	Do you or a member of household need medical care right now 1-Yes, 2-No	PAS SNE	1	A	42	42
008	4	Had you ever heard of health maintenance organization (H	PAS SNE	1	N	43	43

PHRED PROJECT
DETAIL DESIGN DOCUMENTATION
INPUT DESCRIPTION

INPUT NAME
MEMBERSHIP STUDIES MARKETING ENROLLMENT

INPUT ID

RECORD NAME
MEMS - MAIL CHOICE ONLY

RECORD NO. RECORD SIZE

FIELD NUMBER	DATA ELEMENT NUMBER	FIELD NAME	PROCEDURE INSTRUCTIONS	FIELD SIZE	DATA TYPE	POSITION FROM	POSITION THRU
010	CONTACT	Method of Contact 1-Home Visit, 2-Telephone Call, 3-Mail	Enter Item Checked, If not SNE	1	N	45	45
011	PLAN	Plan Number Code plan contract number	Enter hand-written numberber on RH Side	2	N	46	47
012	1.1	Relationship (Self)	PAS SNE	8	A	48	55
013	1.2	Sex (M or F)	PAS SNE	1	A	56	56
014	1.3	Birthdate (MMDDYY format)	PAS SNE	6	N	57	62
015	1.4	Choice A-Enroll, B-Learn, C-Monthly Sticker	Punch Item Marked, SNE	1	A	63	63
016	2.1	Relationship B Codes-Mother, Daughter, Son, Sister, Father, Husband	PAS SNE	8	A	64	71
017	2.2	Sex (M or F)	PAS SNE	1	A	72	72
018	2.3	Birthday B (MMDDYY Format)	PAS SNE	1	A	73	73
019	2.4	Choice A-Enroll, B-Learn, C-Monthly Sticker	Punch Item Marked, SNE	1	A	74	74
020	3.1	Relationship C Codes same as 015	PAS SNE	8	A	75	82
021	3.2	Sex (M or F)	PAS SNE	1	A	83	83
022	3.3	Birthdate C (MMDDYY Format)	PAS SNE	6	N	84	89
023	3.4	Choice C A-Enroll, B-Learn C-Monthly Sticker	Punch Item Marked, SNE	1	A	90	90

PHRED PROJECT
DETAIL DESIGN DOCUMENTATION
I N P U T D E S C R I P T I O N

INPUT NAME
MEMBERSHIP STUDIES MARKETING ENROLLMENT

INPUT ID

RECORD NAME
MEMS MAIL CHOICE ONLY

RECORD NO. RECORD SIZE

FIELD NUMBER	DATA ELEMENT NUMBER	FIELD NAME	PROCEDURE INSTRUCTIONS	FIELD SIZE	DATA TYPE	POSITION FROM	POSITION THRU
024	4.1	Relationship D Codes same as 015	PAS SNE	8	A	91	99
025	4.2	Sex D (M or F)	PAS SNE	1	A	100	100
026	4.3	Birthdate D (MMDDYY Format)	PAS SNE	6	N	101	107
027	4.4	Choice D A-Enroll, B-Learn C-Monthly Sticker	Punch Item Marked	1	A	108	108
028	5.1	Relationship E	PAS SNE	8	A	109	116
029	5.2	Sex E (M or F)	PAS SNE	1	A	117	117
030	5.3	Birthdate E (MMDDYY Format)	PAS SNE	6	N	118	123
031	5.4	Choice E A-Enroll, B-Learn C-Monthly Sticker	Punch Item	1	A	124	124

PHRED PROJECT
DETAIL DESIGN DOCUMENTATION
I N P U T D E S C R I P T I O N

INPUT NAME
MEMBERSHIP STUDIES/MARKETING ENROLLMENT

INPUT ID
HSA00-53

RECORD NAME
MEMS - MAIL CHOICE/MIF/FOLLOW-UP

RECORD NO.

RECORD SIZE
410

FIELD NUMBER	DATA ELEMENT NUMBER	FIELD NAME	PROCEDURE INSTRUCTIONS	FIELD SIZE	DATA TYPE	POSITION FROM	POSITION THRU
001	ID	Identification	RNFF	6	AN	1	6
002	IDF	Form Type Enter CO for all forms of this type	CO or b	2	A	7	8
003	IDN	Name--Enter as Shown (First line of label only) space between | | | |	PAS SNE	30	A	9	38
004	1	Do you have a regular source of health care	PAS SNE	1	N	39	39
005	2	If you or a member of household is sick where to you usually go for care 1-Private Doctor 2-County Clinic 3-County Hospital 4-Emergency Room 5-Other	PAS SNE	1	N	40	40
006	DECIDE	Please tell us what you have decided about your health care by marking A-Enroll, B-HMO, but Sticker, C-Sticker	Enter Item Circle, If Not SNE	1	A	41	41
007	3	Do you or a member of your household need medical care now 1-Yes, 2-No	PAS SNE	1	A	42	42
008	4	Had you ever heard of health maintenace organizations (HMOs) before you received this 1-Yes, 2-No	PAS SNE	1	N	43	43
009	5	Ever joined an HMO 1-Yes, 2-No	PAS SNE	1	N	44	44

PHRED PROJECT
DETAIL DESIGN DOCUMENTATION
I N P U T D E S C R I P T I O N

INPUT NAME
MEMBERSHIP STUDIES/MARKETING ENROLLMENT

INPUT ID
VOLUME - 2000

RECORD NAME
MEMS - MAIL CHOICE ONLY

RECORD NO. RECORD SIZE
403

FIELD NUMBER	DATA ELEMENT NUMBER	FIELD NAME	PROCEDURE INSTRUCTIONS	FIELD SIZE	DATA TYPE	POSITION FROM	POSITION THRU
010	CONTACT	Method of Contact 1-Home Visit, 2-Telephone Call, 3-Mail	Enter Item Checked-If Not SNE	1	N	45	45
011	PLAN	Plan Number Code plan contract number	Enter hand-written number on RH side	2	N	46	47
012	1.1	Relationship (Self)	PAS SNE	8	A	48	55
013	1.2	Sex (M or F)	PAS SNE	1	A	56	56
014	1.3	Birthdate (MMDDYY Format)	PAS SNE	6	N	57	62
015	1.4	Choice A-Enroll, B-Learn, C-Monthly Sticker	Punch Item Marked, SNE	1	A	63	63
016	2.1	Relationship B Codes- Mother, Daughter, Son, Sister, Father, Husband	PAS SNE	8	A	64	71
017	2.2	Sex (M or F)	PAS SNE	1	A	72	72
018	2.3	Birthdate B (MMDDYY Format)	PAS SNE	6	N	73	78
019	2.4	Choice A-Enroll, B-Learn, C-Monthly Sticker	Punch Item Marked, SNE	1	A	79	79
020	3.1	Relationship C Codes same as 016	PAS SNE	8	A	80	87
021	3.2	Sex (M or F)	PAS SNE	1	A	88	88
022	3.3	Birthdate C (MMDDYY Format)	PAS SNE	6	N	89	94
023	3.4	Choice A-Enroll, B-Learn, C-Monthly Sticker	Punch Item Marked, SNE	1	A	95	95

PHRED PROJECT
DETAIL DESIGN DOCUMENTATION
I N P U T D E S C R I P T I O N

INPUT NAME
MEMBERSHIP STUDIES/MARKETING ENROLLMENT

INPUT ID
VOLUME - 2000

RECORD NAME
MEMS - MAIL CHOICE ONLY

RECORD NO. RECORD SIZE
403

FIELD NUMBER	DATA ELEMENT NUMBER	FIELD NAME	PROCEDURE INSTRUCTIONS	FIELD SIZE	DATA TYPE	POSITION FROM	POSITION THRU
024	4.1	Relationship D	PAS SNE	8	A	96	103
025	4.2	Sex (M or F)	PAS SNE	1	A	104	104
026	4.3	Birthdate D (MMDDYY Format)	PAS SNE	6	N	105	110
027	4.4	Choice A-Enroll, B-Learn, C-Monthly Sticker	Punch Item Marked, SNE	1	A	111	111
028	5.1	Relationship (Self)	PAS SNE	8	A	112	119
029	5.2	Sex (M or F)	PAS SNE	1	A	120	120
030	5.3	Birthdate (MMDDYY Format)	PAS SNE	6	N	121	126
031	5.4	Choice A-Enroll, B-Learn, C-Monthly Sticker	Punch Item Marked, SNE	1	A	127	127

PHRED PROJECT
DETAIL DESIGN DOCUMENTATION
I N P U T D E S C R I P T I O N

INPUT NAME
MEMBERSHIP MAIL

INPUT ID

RECORD NAME
MAIL INFORMATION FORM (MIF)

RECORD NO. RECORD SIZE

FIELD NUMBER	DATA ELEMENT NUMBER	FIELD NAME	PROCEDURE INSTRUCTIONS	FIELD SIZE	DATA TYPE	POSITION FROM	POSITION THRU
032	ID	Identification	RNIF	7	N	128	134
033	IDF	Form Type	PAS	1	A	135	135
034	1	Mail Batch Number	PAS	6	AN	136	141
035	2	Date received by PHRED (MMDDYY Format)	PAS SNE	6	N	142	147
036	3	Date mailed to PHRED (MMDDYY Format)	PAS SNE	6	N	148	153
037	PLAN	Plan contract number code plan contract #	Enter Code Written In	2	N	154	155
038	4	Referral's name Last, First, Middle)	TTF,b between	30	N	156	186
039	5	Medi-Cal Number	LJ, If not FF	14	N	187	200
040	6A	Address (House, Number, Street, Road)	TTF,b between	30	AN	201	231
041	6B	City	TTF,b between	16	A	232	247
042	6C	County	TTF,b between	12	A	248	259
043	7	Zip Code	PAS SNE	5	N	260	264
044	8	Telephone Number (XXX)Area Code (XXX-XXXX)	PAS SNE	10	N	265	274
045	9	Type of Referral 1-Self, Result of Mailer 2-Other	PAS SNE	1	N	275	275
046	10A	Indicated Interest 1-Enroll, 2-Learn About	PAS SNE	1	N	276	276
047	10B	Contact Person with (XX) days	RJ PZ	2	N	277	278
048	11	Method of Contact 1-By Phone, 2-At Home, 3-By Mail	PAS SNE	1	N	279	280
049	12	Return to PHRED by (MMDDYY Format)	PAS SNE	6	N	281	286
050	13	How many times was the individual contacted	RJ PZ	2	N	287	288
051	14	Date of First Contact (MMDDYY Format)	PAS SNE	6	N	289	294

PHRED PROJECT
DETAIL DESIGN DOCUMENTATION
I N P U T D E S C R I P T I O N

INPUT NAME
MEMBERSHIP MAIL

INPUT ID

RECORD NAME
MAIL INFORMATION FORM (MIF)

RECORD NO. RECORD SIZE

FIELD NUMBER	DATA ELEMENT NUMBER	FIELD NAME	PROCEDURE INSTRUCTIONS	FIELD SIZE	DATA TYPE	POSITION FROM	POSITION THRU
052	15	Method of Contact 1-Phone, 2-Mail, 3-Home, 4-Walk-In	PAS SNE	1	N	295	295
053	16	Results of First Contact 1-Verified Enrollee 2-Enrolled Other Plan 3-No Contact 4-Decision Pending 5-Stay on Regular Medi-Cal 6-Advanced Enrollment 7-Other	PAS SNE	1	N	296	296
054	17	Date of Last Contact (MMDDYY Format)	PAS SNE	6	N	297	302
055	18	Method of Last Contact 1-Phone, 2-Mail, 3-Home, 4-Walk-In	PAS SNE	1	N	303	303
056	19	Results of Last 1-Verified Enrollee, 2-Enrolled Other Plan, 3-No Contact, 4-Decision Pending 5-Stay on Regular Medi-Cal 6-Advanced Enrollment, 7-Other	PAS SNE	1	N	304	304
057	20	How many person enrolled	RJ PZ	2	N	305	306
058	21	Does this represent the referral's total family 1-Yes, 2-No	PAS SNE	1	N	307	307
059	22	Date returned to PHRED (MMDDYY Format)	PAS SNE	6	N	308	313

PHRED PROJECT
DETAIL DESIGN DOCUMENTATION
I N P U T D E S C R I P T I O N

INPUT NAME
MEMS MAIL

INPUT ID

RECORD NAME
PHONE FOLLOW-UP INFORMATION FORM (PFIF)

RECORD NO. RECORD SIZE

FIELD NUMBER	DATA ELEMENT NUMBER	FIELD NAME	PROCEDURE INSTRUCTIONS	FIELD SIZE	DATA TYPE	POSITION FROM	POSITION THRU
060	ID	Identification	RNFF	7	N	314	320
061	IDF	Type of Form	(F or b)	1	A	321	321
062	IDN	Medi-Cal Number	LJ NFF	14	N	322	335
063	1	Contact Method (1-4) 1-Mail, 2-At Home, 3-Social Service Office 4-Other	PAS SNE	1	N	336	336
064	2A	Want to join a PHP 1-Yes, 2-No	PAS SNE	1	N	337	337
065	2B	Stay on regular Medi-Cal 1-Yes, 2-No	PAS SNE	1	N	338	338
066	3	Agreement to Interview 1-Yes, 2-No	PAS SNE	1	N	339	339
067	4	What did you think you had to do when you received the mailing	PAS SNE	1	N	340	340
068	5	Did mailing help you 1-Yes, 2-No, 3-Other	PAS SNE	1	N	341	341
069	6	Head of Household 1-Yes, 2-No	PAS SNE	1	N	342	342
070	7	How old are you	PAS SNE	2	N	343	344
071	8	Marital Status 1-Married, 2-Divorced 3-Single, 4-Separated 5-Widowed, 6-Other	PAS SNE	1	N	345	345
072	9	Highest Grade in School (XX 00-99)	RZ PZ	2	N	346	347
073	10	How many Children	RJ PZ	2	N	348	349
074	11	Age of youngest child	RJ PZ	2	N	350	351
075	12	Age of oldest child	RJ PZ	2	N	352	353
076	13	Language spoken at home 1-English, 2-Spanish, 3-Other	PAS SNE	1	N	354	354
077	14	Ethnicity 1-Asian, 2-Black, 3-Filipino, 4-Hispanic, 5-Native American, 6-White, 7-Other	PAS SNE	1	N	355	355

PHRED PROJECT
DETAIL DESIGN DOCUMENTATION
I N P U T D E S C R I P T I O N

INPUT NAME
MEMS MAIL

INPUT ID

RECORD NAME
PHONE FOLLOW-UP INFORMATION FORM (PFIF)

RECORD NO. RECORD SIZE

FIELD NUMBER	DATA ELEMENT NUMBER	FIELD NAME	PROCEDURE INSTRUCTIONS	FIELD SIZE	DATA TYPE	POSITION FROM	POSITION THRU
078	15	Do you have a family doctor right now 1-Yes, 2-No	PAS SNE	1	N	356	356
079	16	Satisfaction with current care 1-Very Satisfied 2-Satisfied 3-So-So 4-Dissatisfied 5-Very Dissatisfied	PAS SNE	1	N	357	357
080	17	How many times seen a doctor in the last year (00-99)	RJ PZ	2	N	358	359
081	18	How many times other members of the household seen a doctor in the last year (00-99)	RJ PZ	2	N	360	361
082	19	How many times hospitalized in the last year (00-99)	RJ PZ	2	N	362	363
083	20	How many times household members hospitalized in last year (00-99)	RJ PZ	2	N	364	365
*084	21	Need medical care right now 1-Yes, 2-No	PAS SNE	1	N	366	366
*085	22	Heard of prepaid health plans before 1-Yes, 2-No 3-Don't Know	PAS SNE	1	N	367	367
*086	23	You or anyone in your household ever joined a PHP before 1-Yes, 2-No 3-Don't Know	PAS SNE	1		368	368
*087	24A	Main reason for joining a PHP (0-9)	PAS SNE	1	N	369	369

*SEE CODES

PHRED PROJECT
DETAIL DESIGN DOCUMENTATION
I N P U T D E S C R I P T I O N

INPUT NAME
MEMS MAIL

INPUT ID

RECORD NAME
PHONE FOLLOW-UP INFORMATION FORM (PFIF)

RECORD NO. RECORD SIZE

FIELD NUMBER	DATA ELEMENT NUMBER	FIELD NAME	PROCEDURE INSTRUCTIONS	FIELD SIZE	DATA TYPE	POSITION FROM	POSITION THRU
*088	24B	Services under one roof 1-Yes, 2-False 3-Don't Know	PAS SNE	1	N	370	370
*089	24C	Other Reasons (0-9)		1	N	371	371
*090	24D	Stay on regular Medi-Cal (0-9)	PAS SNE	1	N	372	372
*091	24E	Was it important to keep you own doctor 1-Yes, 2-False 3-Don't Know	PAS SNE	1	N	373	373
*092	24F	Other important reasons (0-9)	PAS SNE	1	N	374	374
*093	25A	What is the most important thing PHPs should do for you (0-9)	PAS SNE	1	N	375	375
*094	25B	What is the most important thing that regular Medi-Cal should do for you (0-9)	PAS SNE	1	N	376	376
095	26	Has anyone from the health plan called or come by to see you to ask if you had questions about the services 1-Yes, Phone, 2-Yes, Home, 3-Yes, Other, 4-Other	PAS SNE	1	N	377	377
096	27	Have you received a plan booklet explaining the services 1-Yes, 2-No 3-Don't Know	PAS SNE	1	N	378	378

PHRED PROJECT
DETAIL DESIGN DOCUMENTATION
I N P U T D E S C R I P T I O N

INPUT NAME
MEMS MAIL

INPUT ID

RECORD NAME
PHONE FOLLOW-UP INFORMATION FORM (PFIF)

RECORD NO. RECORD SIZE

FIELD NUMBER	DATA ELEMENT NUMBER	FIELD NAME	PROCEDURE INSTRUCTIONS	FIELD SIZE	DATA TYPE	POSITION FROM	POSITION THRU
097	28	Joining the plan was completely voluntary and you don't have to enroll to keep your food stamps or aid 1-Yes, 2-No 3-Don't Know	PAS SNE	1	N	379	379
098	29A	After 30 days you can disenroll (get out) for any reason 1-Yes, 2-No 3-Don't Know	PAS SNE	1	N	380	380
099	29B	After 30 days you can disenroll if you are dissatisfied after you use the plans grievance system 1-Yes, 2-No 3-Don't Know	PAS SNE	1	N	381	381
100	30	Did anyone check to see if you were under a doctor's care 1-Yes, 2-No 3-Don't Know	PAS SNE	1	N	382	382
101	31	After your enrollment begins you can't go to your current doctor unless he/she is on the list 1-Yes, 2-No 3-Don't Know	PAS SNE	1	N	383	383
102	32	Until then do you know how to get health care 1-Yes, 2-No 3-Don't Know	PAS SNE	1	N	384	384
103	33	Prepaid health plans part of Medi-Cal 1-Yes, 2-False 3-Don't Know		1	N	385	385

PHRED PROJECT
DETAIL DESIGN DOCUMENTATION
I N P U T D E S C R I P T I O N

INPUT NAME
MEMS MAIL

INPUT ID

RECORD NAME
PHONE FOLLOW-UP INFORMATION FORM (PFIF)

RECORD NO. RECORD SIZE

FIELD NUMBER	DATA ELEMENT NUMBER	FIELD NAME	PROCEDURE INSTRUCTIONS	FIELD SIZE	DATA TYPE	POSITION FROM	POSITION THRU
104	34	Regular Medi-Cal and prepaid Medi-Cal provide basic health care at no extra cost to you 1-Yes, 2-False 3-Don't Know	PAS SNE	1	N	386	386
105	35	People eligible of Medi-Cal may choose between regular Medi-Cal and prepaid Medi-Cal 1-Yes, 2-False 3-Don't Know	PAS SNE	1	N	387	387
106	36	PHPS offer extra services that regular Medi-Cal doesn't 1-Yes, 2-False 3-Don't Know	PAS SNE	1	N	388	388
107	37	People who use regular Medi-Cal have to use the same doctor all the time 1-Yes, 2-False 3-Don't Know	PAS SNE	1	N	389	389
108	38	Prepaid Medi-Cal you go to that plans facilities except in emergencies when you can't get there 1-Yes, 2-False 3-Don't Know	PAS SNE	1	N	390	390
109	39	People on Medi-Cal who go to PHPs are guaranteed health care by the plan 1-Yes, 2-False 3-Don't Know	PAS SNE	1	N	391	391

PHRED PROJECT
DETAIL DESIGN DOCUMENTATION
I N P U T D E S C R I P T I O N

INPUT NAME
MEMS MAIL

INPUT ID

RECORD NAME
PHONE FOLLOW-UP INFORMATION FORM (PFIF)

RECORD NO. RECORD SIZE

FIELD NUMBER	DATA ELEMENT NUMBER	FIELD NAME	PROCEDURE INSTRUCTIONS	FIELD SIZE	DATA TYPE	POSITION FROM	POSITION THRU
110	40	PHPs allow their members to go anywhere they want to for health care 1-Yes, 2-False 3-Don't Know	PAS SNE	1	N	392	392
111	41	People using regular Medi-Cal must find their own doctor 1-Yes, 2-False 3-Don't Know	PAS SNE	1	N	393	393
112	42	It may take approximately 60 days to disenroll from a prepaid health plan 1-Yes, 2-False 3-Don't Know	PAS SNE	1	N	394	394
113	43	Correct Address 1-Yes, 2-No	PAS SNE	1	N	395	395
114	44	Interviewer (XX) 1-Marguerite 2-Suzanne 3-Bob 4-Kathy Green 5-Anthony 6-Tom Buser 7-Jo	Enter As Shown	2	A/N	396	397
115	45	Date of Interview (YYDDD - Julian)	PAS SNE	5	N	398	402
*116	46	Clock Time of Interview	PAS SNE	4	N	403	406
117	47	Number of Tries (XX 01-99)	RJ PZ	2	N	407	408
118	48	Interview Time (In Minutes)	RJ PZ	2	N	409	410

*9999 - Mailed Out Forms

III. Current Method

Current Method (CM)--The current method is best described as the plans' usual marketing method (primarily door-to-door solicitation by plan representatives). The forms used for this method included:

Presentation Results Form (PRF)--information on plan contacts for their usual marketing methods.

Phone Follow-Up Information Form (PFIF)*--demographic, comprehension, and retention information, and attitudes about Medi-Cal and health care.

*This instrument was the same for all three major methods.

State of Californ... Health and Welfare Agency

PRESENTAT... ESULTS REPORT

Departm... Health Services

Name of Rep...

Name of Plan:

Method:

Date:

(1) a. Street b. City	(2) Street Number	(3) Apt. Number	(4) Person Home? Yes/No	(5) a. Name of Person Contacted b. Medi-Cal Number	(6) Eligible for PHP Yes/No	(7) Name of PHP If Enrolled	(8) Presentation Made Yes/No	(9) Refusal of Presentation Yes/No/NA	(10) Number of Enrollments	(11) Number of Persons in Family	(12) Time Started (Ex.: 12:15 P.M.)	(13) Time Ended (Ex.: 12:30 P.M.)	(14) Time in Transit (Ex.: 010 Min.)	(15) a. Phone Number (If Available b. Notes (Explain Nos. in 8 & 9 and Discrepancy in 10 & 11)
a.				a.										a.
b.				b.										b.
a.				a.										a.
b.				b.										b.
a.				a.										a.
b.				b.										b.
a.				a.										a.
b.				b.										b.
a.				a.										a.
b.				b.										b.
a.				a.										a.
b.				b.										b.
a.				a.										a.
b.				b.										b.

06-1

MC 730 (12/79)

PRESENTATION RESULTS FORM

1. |__|__|__|__|__|__|__|__|
   Sequence/Batch No.

2. |__|__|Plan

3. |__|__|__|__|__|__|
   (Date, Julian)

4. |_____|
   Name

5. |_____|
   Address

   |_____|__|__|__|__|__|
   Zip

6. On Medi-Cal or eligible? |___|

7. |_____|
   Medi-Cal No.

8. |___| PHP (if enrolled)

9. |__| No Contact

10. |__| FFS 11. |__| PHP

12. Presentation |___|
    1=Yes
    2=No, Refused
    3=Other

13. Number of enrolls |__|__|

14. Number of Persons in Family |___|___|

15. Time Started|__|__|__|__|AM/PM

16. Time Ended |__|__|__|__|AM/PM

17. Time in Transit|__|__|__|
    (In minutes)

State of California—Health and Welfare Agency

Department of Health Services

F

PHONE FOLLOW–UP INFORMATION FORM (PFIF)

(To be used to collect demographic, choice factor, comprehension, and verification data)

I
Completed ☐
Follow-Up ☐
II
Mailer ☐
Current ☐
In-Office ☐
III
Enrolled ☐
Not Enrolled ☐

INSTRUCTIONS TO THE INTERVIEWER: Fill in as much information as possible before the contact. When using the probe/comment response, circle the appropriate category and write in phrase/question. Make sure that the proper sections are completed for each individual.

Medi-Cal Number _____ Phone ____-____-____

SECTION I – ALL PERSONS

Hello, is this Mrs. / Ms. / Mr. _____? My name is _____, I am with the Department of Health Services.

1. Recently you were contacted: ☐ 1) by mail ☐ 2) at home ☐ 3) at the Social Service office ☐ 4) Other _____ about joining a pre-paid health plan. You were asked to choose between a PHP and your regular Medi-Cal card. *Probe/Comment* _____ 1. _____

2. I have down here that you want to:
   ☐ A) Join a/ _____ PHP with _____ Other members of your family. Is this correct?
   ☐ 1) Yes, continue
   ☐ 2) No, *Probe/Comment* _____ 2A. _____

   ☐ B) Stay with regular Medi-Cal. Is this correct?
   ☐ 3) Yes, continue
   ☐ 4) No, *Probe/Comment* _____ 2B. _____

I would really appreciate it if you would take a few minutes and discuss your decision with me. The Department of Health Services is very interested in improving how health care is provided to you. One important way that we can do that is by getting your opinions.

3. Is this all right with you?
   ☐ 1) Yes, continue
   ☐ No, then *Probe: Is there some other time that I could call back that would be more convenient for you?*
   ☐ 2) Yes, take time and date: _____
   ☐ 3) No, thank respondent for time and say good-bye. 3. _____

SECTION II – MAIL RESPONDENTS ONLY

First, Mrs. / Ms. / Mr. _____, I'd like to ask you two questions about the mail packet that you received from the department.

4. What did you think you had to do when you got the mailing?
   ☐ 1) Enroll in a plan. ☐ 2) Get more information
   ☐ 3) Send back card to stay on Medi-Cal ☐ 4) Nothing ☐ 5) Other 4. _____

5. Did the mailing help you?
   ☐ 1) Yes, *Comment:* _____
   ☐ 2) No, *Comment:* _____
   ☐ 3) Other, *Comment:* _____ 5. _____

SECTION III DEMOGRAPHICS – MAIL, CURRENT METHOD ONLY

Now, Mrs. / Ms. / Mr. _____, I'd like to ask you some general questions about you and your family.

6. Are you the head of the household?
   ☐ 1) Yes – ask questions in "YOU" format
   ☐ 2) No – ask questions in "HEAD OF HOUSEHOLD" format and
   PROBE: Who is? _____ 6. _____

7. How old are you/head of household? _____ years 7. _____

8. What is your/head of household's marital status?
   ☐ 1) married ☐ 2) divorced ☐ 3) single ☐ 4) separated ☐ 5) widowed ☐ 6) other 8. _____

9. What was your/head of household's highest grade completed in school? _____ years 9. |_|_|

10. How many children are in the household? |_|_| children 10. |_|_|

11. How old is the youngest child? |_|_| years 11. |_|_|

12. How old is the oldest child? |_|_| years 12. |_|_|

13. What language is spoken in your home? ☐ 1) English ☐ 2) Spanish ☐ 3) Other: _____ 13. _____

14. What would you say is your ethnic background?
   ☐ 1) Asian ☐ 2) Black ☐ 3) Filipino ☐ 4) Hispanic
   ☐ 5) Native American ☐ 6) White ☐ 7) Other_____ 14. _____

SECTION IV. A CHOICE FACTORS – HEALTH, ALL PERSONS

Next, Mrs. / Ms. / Mr. _____, I'd like to ask you about you and your family's health.

15. Do you have a family doctor right now?
   ☐ 1) Yes
   ☐ 2) No, then *PROBE: Where to you get most of your care right now?* _____ 15. _____

16. How satisfied are you with the care you are receiving from _____ ? Would you say you are:
   ☐ 1) Very Satisfied ☐ 2) Satisfied ☐ 3) So-So ☐ 4) Dissatisfied ☐ 5) Very Dissatisfied
   Comment: _____ 16. _____

17. How many times have you/head of household seen a doctor in the last year? _____ times 17. |_|_|

18. How many times have other members of the household seen a doctor in the last year? _____ times 18. |_|_|

19. How many times have you/head of household been hospitalized in the last year? _____ times 19. |_|_|

20. How many times have other members of your household been hospitalized in the last year? _____ times 20. |_|_|

21. Do you or any members of your household need medical care right now?
   ☐ 1) Yes ☐ 2) No *Probe/Comment:* _____ 21. _____

SECTION IV.B CHOICE FACTORS -- DECISION, ALL PERSONS

Next set of questions is about your decision to:
☐ Join a PHP ☐ Stay with regular Medi-Cal

22. Had you ever heard of pre-paid health plans before you were contacted?
☐ 1) Yes ☐ 2) No *Probe/Comment:* _____ 22. _____

23. Have you or anyone in your household ever joined a PHP before?
☐ 1) Yes ☐ 2) No *Probe/Comment:* _____ 23. _____

24. What would you say is the main reason why you decided to: 24.
A ☐ Join a PHP? _____ A _____
B *PROBE: Was it important to you that all of the services were under one roof?*
☐ 1) Yes ☐ 2) No _____ B _____
C *PROBE: What other reasons were important to you?* _____ C _____
D ☐ Stay with regular Medi-Cal? _____ D _____
E *PROBE: Was it important to you to choose your own doctor?*
☐ 1) Yes ☐ 2) No _____ E _____
F *PROBE: What other reasons were important to you?* _____
_____ F _____

25. What would you say is the most important thing that 25.
A ☐ PHPS should do for you? _____ A _____
B ☐ Regular Medi-Cal should do for you? _____ B _____

SECTION V VERIFICATION -- ENROLLEES ONLY

We'd like to check with you on some things that have or will be happening with your enrollment.

26. Has anyone from the health plan called or come to see you to ask if you have any questions about services?
A. Yes ☐ 1) Phone verification ☐ 2) Home verification ☐ 3) Other _____
B. No ☐ 4) 26. _____

27. Have you received a plan booklet explaining the services available?
☐ 1) Yes ☐ 2) No *Comment:* _____ 27. _____

28. Do you understand that joining the plan was completely voluntary and that you don't have to enroll to keep your food stamps or aid?
☐ 1) Yes ☐ 2) No *Comment:* _____ 28. _____

29A. Do you understand that during the first 30 days of membership you can disenroll (get out) for any reason? 29.
☐ 1) Yes ☐ 2) No *Comment:* _____ A _____

29B. Do you understand that after the first 30 days you can disenroll if you are dissatisfied after you use the plan's grievance system.
☐ 1) Yes ☐ 2) No *Comment:* _____ B _____

30. Did anyone check to see if you were under a doctor's care?
☐ 1) Yes ☐ 2) No *Comment:* _____ 30. _____

31. Do you understand that after your enrollment begins you can't to back to your current doctor unless he or she is on the list?
☐ 1) Yes ☐ 2) No *Comment:* _____ 31. _____

32. Your enrollment will probably be effective _____, you will know because you won't get your Medi-Cal card and the plan will send you an ID card instead. Until then, do you know how to get health care?
☐ 1) Yes ☐ 2) No *Advise:* _____ 32. _____

SECTION VI COMPREHENSION QUESTIONS – ALL RESPONDENTS

The last thing I'd like to do is see how well *WE* presented information about health care to you by asking you some questions about PHPs and regular Medi-Cal. Just answer TRUE if you think the question is true, or FALSE if you think the question is false: *Probe/Comment:* _____

Code 1 = Yes 2 = No

33.	T	F	Pre-paid health plans are part of Medi-Cal.	33. _____
34.	T	F	Both regular Medi-Cal and pre-paid Medi-Cal provide basic health care at no cost to you.	34. _____
35.	T	F	People who are eligible for Medi-Cal may choose between regular Medi-Cal and pre-paid Medi-Cal.	35. _____
36.	T	F	Sometimes PHPs offer extra services that regular Medi-Cal doesn't.	36. _____
37.	T	F	People who use regular Medi-Cal have to use the same doctor all the time.	37. _____
38.	T	F	If you are using pre-paid Medi-Cal, you must go to that plan's facilities except in emergencies when you can't get there.	38. _____
39.	T	F	People on Medi-Cal who go to PHPs are guaranteed health care by the plan.	39. _____
40.	T	F	PHPs allow their members to go anywhere they want for health care.	40. _____
41.	T	F	People using regular Medi-Cal must find their own doctors.	41. _____
42.	T	F	It may take approximately 60 days to disenroll from a pre-paid health plan.	42. _____

Thank you very much Mrs. / Ms. / Mr. _____, for your time and cooperation.

You've been bery helpful. Just one more thing before I go, I'd like to check and see if I have your correct address. Is it still _____

_____

43. ☐ 1) Yes
☐ 2) No, get correct address. 43. _____

COMMENTS:

_____

_____

_____

_____

44. INTERVIEWER: _____ 44. |___|___|

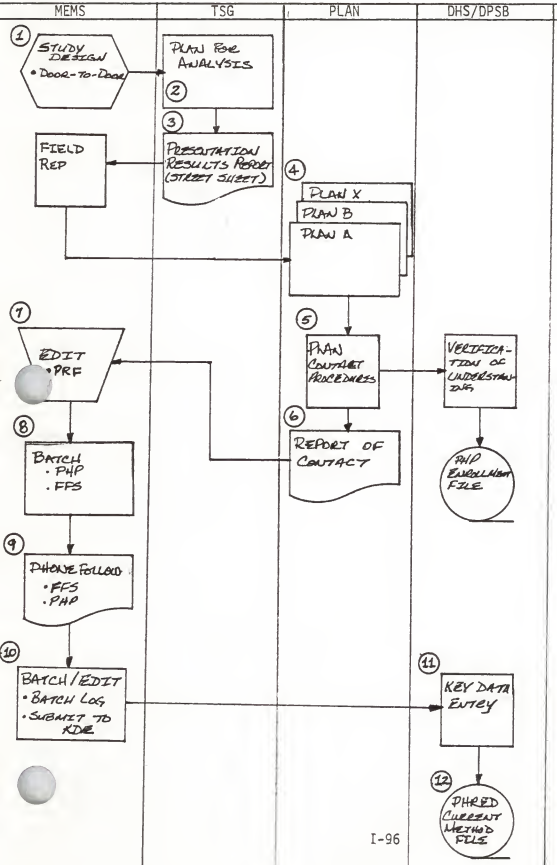
45. DATE: _____ 45. |___|___|___|

46. TIME: _____ 46. |___|___|___|___|

47. Number of Tries: _____ 47. |___|___| |___|___|

48. Amount of Interview Time: _____ 48. |___|___| |___|___| Minutes

DOOR-TO-DOOR
SEQUENCE/DOCUMENT FLOW/CONTROL/RESPONSIBILITY



1) Study design as a series of questions to answer.
2) Plan for analysis
   - output definitions
   - process flow
   - data collection
3) Report of contact developed & disseminated via Field Reps by PHRED. Contains:
   - name
   - enroll/not enroll
   - Medi-Cal number
   - address/phone
   - number in family
   - time spent
   - type of contact
4) Plan uses this or some useable variant.
5) Plan contacts client within its service area.
6) Report of contact form or copy is returned bi-weekly to PHRED for processing.

MEMS	TSG	PLAN	DHS/DPSB

7) Edit- MEMS Clerk checks returning presentation results reports for minimum requirements.
COMPLETE A PRE ALL LOW THERS.

8) Batch - MEMS Clerk

- enters sequence number and stamps and schedules phone follow up of PHP choosers
- samples FFS choosers enters sequence num and stamps and schedules phone follow-up of FFS choosers

9) MEMS Clerk

- phone follow-up on assigned schedule of PHP's & FFS choosers

10) MEMS Clerk

- edits completed PFIF
- compiles batches
- submit to KDE and log out hard copy returned and logged in upon return from KDE

11) Data key entered.

12) Current method (by plan)

FORM CYCLE--STREET SHEET

(Routing, Batching and Logging)

	ACTION	RESPONSIBLE PARTY	NARRATIVE
1.	Route	TSG to MEMS	Forms are printed & distributed to MEMS by TSG. MEMS will be responsible for scheduling the number of forms needed for their respective plans. This number should be kept current with TSG.
2.	Route	MEMS (FR) to Plan	The Field Reps. will be responsible for delivering the street sheets to the plans. If the plans can not use the form developed by PHRED, it will be the Field Rep's. responsibility to ensure that the necessary data is being collected. The Field Reps. will train the plan employees in the proper way to fill out the street sheet for PHRED purposes. The minimum amount of data on the street sheets will be: 1) name (if available), 2) address, 3) phone (if available), 4) results of contact,

	ACTION	RESPONSIBLE PARTY	
2.	Route	MEMS (FR) to Plan	5) number of persons enrolling (if available), 6) number of persons in family (if available) 7) time spent per contact (including travel), 8) Medi-Cal number (if available).
3.	Route Batch	Plans to MEMS Clerk	The plan will contact 200 potential enrollees during specific blocks of time as designated by MEMS. They will record the results of such contacts and field Reps will deliver copies of their street sheets to the MEMS Clerk every other week. To count,a contact must at least have the minimum amount of data specified above. Plans should be informed of the target and their progress towards it on a routine basis
4.	Edit	MEMS Clerk & F.R.	Returning presentation results report (Street Sheet) will be edited to insure that the minimum amount of

	RESPONSIBLE ACTION	PARTY	NARRATIVE
4.	Edit	MEMS Clerk & F.R.	data has been collected by the plan's marketing rep. on both FFS and PHP contacts. If not a call back to the plan will have to be made.
5.	Encode	MEMS Clerk	For every valid contact (up to 200) on the Presentation Results Report Presentation Results Form (PRF) will be filled out and accompany all phone follow-ups (all PHP and 20% FFS).
6.	Batch Process PHP	MEMS Clerk	On the Batch Cover Sheet enter sequence number for each PHP choice, schedule a PFIF (15-18 days after plan's initial contact of person) and stamp the PFIF and PRF with the date (Julian) batch number (50-99) and the sequence number (00-99). Returns for each Plan should be batched separately and enter this along with the complete number on the Batch Control Log for tracking purposes.

	ACTION	RESPONSIBLE PARTY	NARRATIVE
7.	Batch FFS	MEMS Clerk	On the Batch Cover Sheet enter the selected FFS contacts (see General Specs.) stamp and schedule (with dates, batch and sequence number) a PFIF and PRF and a minimum of 15 days after plan contact. At the top of the Batch Cover Sheet enter the Julian date the sheet was received and the batch number (50-99) and sequence number (maximum 99 to a batch). Returns for each plan should be batched separately. On the Batch Cover Log enter the full batch number, the method and what plan that batch originated from in the margin.
8.	Route	MEMS Clerk	When follow-up calls have been completed, PFIF's are ready to be forwarded to KDE via TSG.
9.	Route	TSG to MEMS	TSG will return hard copy to MEMS for storage.

-Instructional Guide-
STREET CONTACT SHEET

Under the Heading, the following spaces need to be completed:

a) Name of representative

b) Name of plan

c) Date

1(a) Street-
Street name on which person contacted lives.

1(b) City-
Name of city in which person contacted lives.

2. Street Number-
House number of person contacted.

3. Apartment Number-
Apartment number of person contacted, if applicable.

4. Person-at-home-
Yes, No, or Not Applicable (N/A). If yes, continue; if no or N/A skip to time block, note start and end times and, if applicable, any in-transit time. Under 17a, "Notes" should indicate the disposition of the contact.

5(a) Name-
Person contacted, coded; Last, First, Middle.

5(b) Medi-Cal Number-
Medi-Cal number of person contacted if available; if not, leave blank

6. Eligible for PHP
Is person contacted eligible to enroll in a PHP? Code: Yes or No.

7. Name of PHP, if enrolled-
If the person contacted is currently enrolled in a PHP, indicate which. If not, write None.

8. Presentation-
Did the enroller make a presentation about the Plan to the person contacted? Code: Yes or No; if no, reason should be given in 17a, "Notes."

9. Refuse Presentation-
Did the person contacted refuse the presentation? Code: Yes or No; if no, indicate reason in 17a, "Notes."

10. Number of Enrollments-
The number of enrollments that this contact directly yielded. Code: Number; Example: 2, 3 or 5.

11. Number of Persons in Family-
The total number of persons in the family. Code: Number; Example: 2, 3 or 7.

12. Time Started-
The time at which work on this contact began. Code: XX:XX AM/PM. Example: 12:30 PM.

13. Time Ended-
The time at which work on this contact ceased. Code: XX:XX AM/PM. Example: 12:45 PM.

14. Time In Transit-
Time spent going or coming from, or waiting for, a face-to-face contact. Code: XXX min. Example: 010 min.

15(a) Phone Number-
The contacted person's telephone number. This item is of extreme importance. It must be obtained if at all possible.

15(b) Notes-
Notes on Disposition, or other notes such as reasons for "No Presentation" or "Refused Presentation." Plans which employ several marketing techniques will indicate which was used here.

Instructional Guide
Presentation Results Form

1. Sequence number - enter the appropriate batch/sequence number for that document with the automatic numbering machine.

2. Plan - enter the Prepaid Health Plan contact number from which the representative is from. (see attached list)

3. Julian Date - enter date that the contact was made by the field representative in Julian format. (Ex: July 19, 1979--79200)

4. Name - enter name of contact, head of household person with whom the contact was made by the field representative.

5. Address - enter respondents address; house or apartment number, street, city.

5A. Zip - enter respondents zip code.

6. Medi-Cal/Eligible - enter yes/no is respondent eligible to join PHP.

7. Medi-Cal Number - 14 digit Medi-Cal number if on or available.

8. PHP (if enrolled) - enter plan contact number if respondent is already enrolled in a plan. (see attached list)

9. FFS - check if this contact was a fee-for-service choice.

10. PHP - check if this contact was a PHP choice.

11. No Contact - check if this FFS choice did not fall into the follow-up sample for a phone follow-up.

12. Presentation - check yes if the respondent received a presentation; no if the respondent refused the presentation.

13. Number of Enrollees - if the respondent is enrolling, enter the number of persons being enrolled.

14. Number of Persons in Family - If the respondent is enrolling enter the number of persons in the family.

15. Time Started - enter the time recorded by the representative that the presentation to that contact started. (Ex: 10:10) Circle AM or PM as appropriate.

16. Time Ended - enter the time that the presentation to that contact ended. (Ex: 10:30) Circle AM or PM as appropriate.

17. Time in Transit - enter the amount of time the representative took to get to that individual contact. (Ex: 10 minutes).

PLAN LIST

PLAN	CONTACT #
Contra Costa Key Plan	45
HealthCare	86
Rockridge	63
Watts	32
CompreCare	22
CMGHP (LA)	2
CMG (Orange)	23
Kaiser (LA)	28
Kaiser (Orange)	76
HMOC	82
N. E. Valley	55

All reasonable efforts have been made to complete the batch and:

- o it is more than 60 days old (from the time documents were first received at PHRED).
- o at least 75% of the batch is complete.

Current Method

1. Batch and sequence number (See W.O.).

2. Sampling - to select the appropriate number of FFS phone follow-ups, the total number of contacts have to be found. As Street Sheets are returned by plan, after filling out PRF's on all valid contacts count the number of total FFS valid contacts. Take 20 percent of that number (Ex: 20% of total of 100 contacts = 20). This provides the top end of the sample. To find which 20 should be included in the sample, go to the table of random numbers starting from the number underlined in blue, proceed across the column until a number is found that is within the range. Going back to the Street Sheet starting at the beginning select that contact which corresponds to the number from the random number chart. If the contact choosen has incomplete information (Ex: no phone), return to the table and take the next number. As in the W.O. the same bottom limit applies.

   If an FFS batch has much less than 20 persons total, then the following guide should be used:

   1 - 10 All
   11 - 20 Every Other One
   21 - ? Go to table, down the column looking for number within range.

PHRED PROJECT
DETAIL DESIGN DOCUMENTATION
I N P U T D E S C R I P T I O N

INPUT NAME
MEMS CUURENT METHOD

INPUT ID
HAS00-51

RECORD NAME
CURRENT METHOD (PRESENTATION RESULTS FORM)

RECORD NO. RECORD SIZE
211

FIELD NUMBER	DATA ELEMENT NUMBER	FIELD NAME	PROCEDURE INSTRUCTIONS	FIELD SIZE	DATA TYPE	POSITION FROM	POSITION THRU
001	1	Sequence/Batch number	RNIF	7	N	1	7
002	2	Plan (soliciting members) contract number XX	PAS	2	N	8	9
003	3	Date of contact (Julian)	PAS	5	N	10	14
004	4	Name of contact |_____|Ø|_____|Ø|_____|	TTF SNE	14	A	15	28
005	5	Street/Apt. number (Right Justify)	RJ	5	N	29	33
006	5	Name of street/road/ avenue	TTF	14	A	34	47
007	5	City	TTF	14	A	48	61
008	5	Zip Code	PAS SNE	5	N	62	66
009	5A	Telephone Number (Area Code & Number)	PAS SNE	10	N	67	76
010	6	On Medi-Cal & PHP eligible 1-Yes, 2-No, 3-Don't know	PAS	1	N	77	77
011	7	Medi-Cal number	LJ SNE	14	N	78	91
012	8	PHP, if already enrolled (Plan contract number	PAS SNE	2	N	92	93
013	9	No contact (follow-up)	PAS SNE	1	N	94	94
014	10	Fee-for-service (follow-up)	PAS SNE	1	N	95	95
015	11	Prepaid health plan (follow-up)	PAS SNE	1	N	96	96
016	12	Presentation 1-Yes, 2-No, refused 3-Other	PAS SNE	1	N	97	97

PHRED PROJECT
DETAIL DESIGN DOCUMENTATION
I N P U T D E S C R I P T I O N

INPUT NAME
MEMS CURRENT METHOD

INPUT ID

RECORD NAME
PHONE FOLLOW-UP INFORMATION FORM (PFIF)

RECORD NO. RECORD SIZE

FIELD NUMBER	DATA ELEMENT NUMBER	FIELD NAME	PROCEDURE INSTRUCTIONS	FIELD SIZE	DATA TYPE	POSITION FROM	POSITION THRU
017	13	Number of enrolls	RJ SNE	2	N	98	99
018	14	Number of persons in family (XX)	RJ SNE	2	N	100	102
019	15	Time Started (XX:XX)	PAS SNE	4	N	103	106
020	16	Time Ended (XX:XX)	PAS SNE	4	N	107	110
021	17	Time in Transit (XXX-Minutes)	RJ SNE	3	N	111	113
022		Identification	RNFF	7	N	114	120
023		Type of Form	F or Blank	1	A	121	121
024		Medi-Cal Number	LJ if not Full Field	14	N	122	135
025	1	Contact Method (1-4) 1-Mail, 2-At home 3-Social Service Office 4-Other	PAS	1	N	136	136
026	2A	Want to join a PHP 1-Yes, 2-No	PAS SNE	1	N	137	137
027	2B	Stay on regular Medi-Cal 1-Yes, 2-No	PAS SNE	1	N	138	138
028	3	Agreement to Interview	PAS SNE	1	N	139	139
029	4	What do you think you had to do when you received the mailing? (1-5)	PAS SNE	1	N	140	140
030	5	Did mailing help you? 1-Yes, 2-No, 3-Other	PAS SNE	1	N	141	141
031	6	Head of Household 1-Yes, 2-No	PAS SNE	1	N	142	142
032	7	How old are you	PAS SNE	2	N	143	144
033	8	Marital Status 1-Married, 2-Divorced 3-Single, 4-Separated 5-Widowed, 6-Other	PAS SNE	1	N	145	145

PHRED PROJECT
DETAIL DESIGN DOCUMENTATION
I N P U T D E S C R I P T I O N

INPUT NAME
MEMS CURRENT METHOD

INPUT ID

RECORD NAME
PHONE FOLLOW-UP INFORMATION FORM (PFIF)

RECORD NO. RECORD SIZE

FIELD NUMBER	DATA ELEMENT NUMBER	FIELD NAME	PROCEDURE INSTRUCTIONS	FIELD SIZE	DATA TYPE	POSITION FROM	POSITION THRU
034	9	Highest Grade in School (XX 00-99)	RJ PZ	2	N	146	147
035	10	How many children	RJ PZ	2	N	148	149
036	11	Age of Youngest Child	RJ PZ	2	N	150	151
037	12	Age of Oldest Child	RF PZ	2	N	152	153
038	13	Language Spoken at Home 1-English, 2-Spanish 3-Other	PAS SNE	1	N	154	154
039	14	Ethnicity 1-Asian, 2-Black 3-Filipino, 4-Hispanic 5-Native American, 6-White, 7-Other	PAS SNE	1	N	155	155
040	15	Do you have a family doctor right now? 1-Yes, 2-No	PAS SNE	1	N	156	156
041	16	Satisfaction with current care 1-Very Satisfied, 2-Satisfied 3-So-So, 4-Dissatisfied, 5-Very Dissatisfied	PAS SNE	1	N	175	157
042	17	How many times seen a doctor in the last year (00-99)	RJ PZ	2	N	158	159
043	18	How many times other members of the household seen a doctor in the last year (00-99)	RJ PZ	2	N	160	161
044	19	How many times hospitalized in the last year (00-99)	RJ PZ	2	N	162	163
045	20	How many times household members hospitalized in last year (00-99)	RJ PZ	2	N	164	165

PHRED PROJECT
DETAIL DESIGN DOCUMENTATION
INPUT DESCRIPTION

INPUT NAME
MEMS CURRENT METHOD

INPUT ID

RECORD NAME
PHONE FOLLOW-UP INFORMATION FORM (PFIF)

RECORD NO. RECORD SIZE

FIELD NUMBER	DATA ELEMENT NUMBER	FIELD NAME	PROCEDURE INSTRUCTIONS	FIELD SIZE	DATA TYPE	POSITION FROM	POSITION THRU
*046	21	Need medical care right now 1-Yes, 2-No	PAS SNE	1	N	166	166
*047	22	Heard of prepaid health plans before 1-Yes, 2-No, 3-Don't Know	PAS SNE	1	N	167	167
*048	23	You or anyone in your household ever joined a PHP before 1-Yes, 2-No, 3-Don't Know	PAS SNE	2	N	168	169
*049	24A	Main reason for joining a PHP (0-9)	PAS SNE	1	N	170	170
*050	24B	Services under one roof 1-Yes, 2-No, 3-Don't Know	PAS SNE	1	N	171	171
*051	24C	Other reason (0-9)	PAS SNE	1	N	172	172
*052	24D	Stay on regular Medi-Cal (0-9)	PAS SNE	1	N	173	173
*053	24E	Was it important to keep own doctor 1-Yes, 2-No, 3-Don't Know	PAS SNE	1	N	174	174
*054	24F	Other important reason (0-9)	PAS SNE	1	N	175	175
*055	25A	What is the most important thing PHPs should do for you (0-9)	PAS SNE	1	N	176	176

* SEE CODES

PHRED PROJECT
DETAIL DESIGN DOCUMENTATION
I N P U T D E S C R I P T I O N

INPUT NAME
MEMS CURRENT METHOD

INPUT ID

RECORD NAME
PHONE FOLLOW-UP INFORMATION FORM (PFIF)

RECORD NO. RECORD SIZE

FIELD NUMBER	DATA ELEMENT NUMBER	FIELD NAME	PROCEDURE INSTRUCTIONS	FIELD SIZE	DATA TYPE	POSITION FROM	POSITION THRU
*056	25B	What is the most important thing that regular Medi-Cal should do for you (0-9)	PAS SNE	1	N	177	177
057	26	Has anyone from the health plan called or come by to see you to ask if you had questions about the services 1-Yes, Phone, 2-Yes, Home, 3-Yes, Other, 4-Other	PAS SNE	1	N	178	178
058	27	Have you received a Plan booklet explaining the services 1-Yes, 2-No, 3-Don't Know	PAS SNE	1	N	179	179
059	28	Going to the health plan was completely voluntary and you don't have to enroll to keep your food stamps or aid 1-Yes, 2-No, 3-Don't Know	PAS SNE	1	N	180	180
060	29A	After 30 days you can disenroll (get out) for any reason 1-Yes, 2-No, 3-Don't Know	PAS SNE	1	N	181	181

* SEE CODES

PHRED PROJECT
DETAIL DESIGN DOCUMENTATION
I N P U T D E S C R I P T I O N

INPUT NAME
MEMS CURRENT METHOD

INPUT ID

RECORD NAME
PHONE FOLLOW-UP INFORMATION FORM (PFIF)

RECORD NO. RECORD SIZE

FIELD NUMBER	DATA ELEMENT NUMBER	FIELD NAME	PROCEDURE INSTRUCTIONS	FIELD SIZE	DATA TYPE	POSITION FROM	POSITION THRU
061	29B	After 30 days you can disenroll if you are dissatisfied after you use the Plans grievance system 1-Yes, 2-No, 3-Don't Know	PAS SNE	1	N	182	182
062	30	Did anyone check to see if you were under a doctors care 1-Yes, 2-No, 3-Don't Know	PAS SNE	1	N	183	183
063	31	After your enrollment begins you can't go to your current doctor unless he/she is on the list 1-Yes, 2-No, 3-Don't Know	PAS SNE	1	N	184	184
064	32	Until then do you how to get health care 1-Yes, 2-No, 3-Don't Know	PAS SNE	1	N	185	185
065	33	Prepaid health plans part of Medi-Cal 1-Yes, 2-False 3-Don't Know	PAS SNE	1	N	186	186
066	34	Regular Medi-Cal and prepaid Medi-Cal provide basic health care at no cost to you 1-Yes, 2-False, 3-Don't Know	PAS SNE	1	N	187	187

PHRED PROJECT
DETAIL DESIGN DOCUMENTATION
I N P U T D E S C R I P T I O N

INPUT NAME
MEMS CURRENT METHOD

INPUT ID

RECORD NAME
PHONE FOLLOW-UP INFORMATION FORM (PFIF)

RECORD NO. RECORD SIZE

FIELD NUMBER	DATA ELEMENT NUMBER	FIELD NAME	PROCEDURE INSTRUCTIONS	FIELD SIZE	DATA TYPE	POSITION FROM	POSITION THRU
067	35	People eligible for Medi-Cal may choose between regular Medi-Cal and prepaid Medi-Cal 1-Yes, 2-False, 3-Don't Know	PAS SNE	1	N	188	188
068	36	PHPs offer extra services that regular Medi-Cal doesn't 1-Yes, 2-False, 3-Don't Know	PAS SNE	1	N	189	189
069	37	People who use regular Medi-Cal have to use the same doctor all the time 1-Yes, 2-False, 3-Don't Know	PAS SNE	1	N	190	190
070	38	Prepaid Medi-Cal you must go to the Plans facilities except in emergencies when you can't get there 1-Yes, 2-False, 3-Don't Know	PAS SNE	1	N	191	191
071	39	People on Medi-Cal who go to PHPs are guaranteed health care by the Plan 1-Yes, 2-False, 3-Don't Know	PAS SNE	1	N	192	192

PHRED PROJECT
DETAIL DESIGN DOCUMENTATION
I N P U T D E S C R I P T I O N

INPUT NAME
MEMS CURRENT METHOD

INPUT ID

RECORD NAME
PHONE FOLLOW-UP INFORMATION FORM (PFIF)

RECORD NO. RECORD SIZE

FIELD NUMBER	DATA ELEMENT NUMBER	FIELD NAME	PROCEDURE INSTRUCTIONS	FIELD SIZE	DATA TYPE	POSITION FROM	POSITION THRU
072	040	PHPs allow their members to go anywhere they want for health care 1-Yes, 2-False, 3-Don't Know	PAS SNE	1	N	193	193
073	041	People using regular Medi-Cal must find their own doctor 1-Yes, 2-False, 3-Don't Know	PAS SNE	1	N	194	194
074	042	It may take approximately 60 days to disenroll from a prepaid health plan 1-Yes, 2-False, 3-Don't Know	PAS SNE	1	N	195	195
075	043	Correct Address 1-Yes, 2-No	PAS SNE	1	N	196	196
076	044	Interviewer (XX) 1-Marguerite, 2-Suzanne, 3-Bob, 4-Kathy, 5-Anthony, 6-Tom, 7-Jo	RJ PZ	2	N	197	198
077	045	Date of Interview YYDDD (Julian)	PAS SNE	5	N	199	203
078	046	Clock Time of Interview	PAS SNE	4	N	204	207
079	047	Number of Tries (XX) (01-99)	RJ PZ	2	N	208	209
080	048	Interview Time (In Minutes)	RJ PZ	2	N	210	211

APPENDIX J

Acceptability of Methods Survey

Appendix J

Acceptability of Methods Survey

In the design stages of the marketing/enrollment demonstrations, PHRED Project staff recognized that no matter how high the penetration percentage or how low the cost per choice, a viable alternative to door-to-door solicitation would be difficult to implement if it was unacceptable, for whatever reasons, to the principal participants--the HMOs, county, and and state government officials and consumers. Because of the differing perspectives of each group the Project decided to attempt to measure acceptability and included it among the criteria for evaluation of the various methods.

Two surveys were performed. The first was administered to county personnel in the welfare office demonstration sites, the second survey to HMO contractors who had participated in the demonstrations. Overall results of each are discussed below. The early intention was to also survey consumer groups however, on-going liaison with several major organizations indicated support for, and agreement with the replacement of solicitation by dual choice in the welfare office, and a final survey was not carried out.)

I. County Acceptability Survey

An acceptability survey was administered to county workers who participated, either directly or indirectly, in the PHRED Project demonstrations. The survey forms were completed by eligibility workers, supervisors and clerical staff. Due to the one year time span of the demonstrations and the high turnover of county eligibility workers, many of the participants were not available for comment and some of the employees who answered the survey had not been directly involved in the project.

The total number of respondents was 93. Orange County returned 27 survey forms; Contra Costa County, 26; Los Angeles County, 21; and Sacramento, 19. Alameda County provided separate statements.

The results identified some major differences among the counties but all shared one common concern: Eligibility workers do not want to give the dual-choice presentation as a part of their functional responsibilities. Two reasons were given: a lack of time and a desire to separate the dual choice from the eligibility determination process.

Overall, county employees offered about a one-third percentage of "no opinion" and a low percentage of "unacceptable" responses. Many of the workers answered only the questions which pertained directly to the county workers' involvement in the dual-choice process.

The survey questions and responses follow. Los Angeles County responses are included in the total sample but have also been displayed separately because of the preponderance of Health Maintenance Organizations and welfare recipients in that particular county. Contra Costa County responses are also displayed separately for some items because they often represent the other end of the continuum, reflecting the latter's

different experience in an area in which the county itself operates the HMO which has been offered as a Medi-Cal choice in the welfare offices for a number of years.

The complete instrument may be found at the end of this appendix (page _). For the convenience of the reader, each question/item is given below before the results are tabulated and discussed.

Survey Items and Results

1. Method Evaluation

	Time	Comprehension	Objective	Practical
PHRED Representative				
HMO Representative				
County Worker				
Film				
Brochure				

Definitions

Time--Did this method take a reasonable amount of client and EW time?

Comprehension--Did the clients seem to understand the dual choice process? Did the clients ask their EW to re-explain the dual choice?

Objective--Did this method appear unbiased in presenting the two kinds of Medi-Cal?

Practical--If this method is implemented, would it be practical in your office? (Please rate only the method of the presentation using a simple choice form, rather than the paperwork used by the Project.)

Scale

0 = unacceptable 1 = no opinion 2 = acceptable

Table 1a. METHODS
Responses--All Counties

	Time #	Time %	Comprehension #	Comprehension %	Objective #	Objective %	Practical #	Practical %
PHRED Representative								
Unacceptable	14	15%	10	11%	9	10%	17	18%
No opinion	37	40%	45	48%	48	51%	45	49%
Acceptable	42	45%	38	41%	36	39%	31	33%
HMO Representative								
Unacceptable	12	13%	11	12%	20	21%	15	16%
No opinion	47	51%	51	55%	50	54%	50	54%
Acceptable	34	36%	31	33%	23	25%	38	30%
County Worker								
Unacceptable	47	51%	23	25%	18	19%	42	45%
No opinion	30	32%	45	48%	50	54%	35	38%
Acceptable	16	17%	25	27%	25	27%	16	17%
Film								
Unacceptable	5	5%	11	12%	6	6%	17	18%
No opinion	48	52%	59	63%	62	67%	53	57%
Acceptable	40	43%	23	25%	25	27%	23	25%
Brochure								
Unacceptable	5	5%	10	11%	7	8%	10	11%
No opinion	48	52%	55	59%	56	60%	47	50%
Acceptable	40	43%	28	30%	30	32%	36	39%

(N = 93)

The no opinion responses range between 32 percent and 67 percent. The HMO representative method, considered to be one of the most controversial, did not receive a high unacceptable response, overall. The county worker method received the most unacceptable responses. The main areas of concern were time and practicality.

Table 1b. METHODS
Responses--Los Angeles Only

	Time #	Time %	Comprehension #	Comprehension %	Objectives #	Objectives %	Practical #	Practical %
PHRED Representative								
Unacceptable	1	4%	0	0%	0	0%	0	0%
No opinion	10	48%	11	52%	12	57%	12	57%
Acceptable	10	48%	10	48%	9	43%	9	43%
HMO Representative								
Unacceptable	2	10%	0	0%	0	0%	2	10%
No opinion	11	52%	13	62%	15	71%	12	57%
Acceptable	8	38%	8	38%	6	26%	7	33%
County Worker								
Unacceptable	11	52%	5	24%	2	10%	8	38%
No opinion	3	14%	9	43%	12	57%	6	29%
Acceptable	7	33%	7	33%	7	33%	7	33%
Film								
Unacceptable	0	0%	1	4%	0	0%	1	4%
No opinion	7	33%	11	53%	13	62%	13	62%
Acceptable	14	67%	9	43%	8	38%	7	33%
Brochure								
Unacceptable	2	10%	2	10%	2	10%	0	0%
No opinion	12	57%	9	42%	12	57%	11	52%
Acceptable	7	33%	10	48%	7	33%	10	48%

(N = 21)

2. How would you rate the demonstration materials, using the definitions below and the following scale:

0 = unacceptable 1 = no opinion 2 = acceptable

	Comprehensive	Informative	Objective	Interesting
Flip Chart				
Script (Presentation)				
Brochure				
Film				

Definitions

Comprehensive--Was it easy to understand?
Informative--Did it present useful information?
Objective--Was it unbiased in presenting the two kinds of Medi-Cal?
Interesting--Was it interesting to the clients?

Table 2a. MATERIALS
Responses--All Counties

	Comprehensive # %	Informative # %	Objective # %	Interesting # %
Flip Chart				
Unacceptable	14 = 15%	11 = 12%	11 = 12%	17 = 18%
No opinion	54 = 58%	59 = 63%	57 = 61%	62 = 67%
Acceptable	25 = 27%	23 = 25%	25 = 27%	14 = 15%
Script				
Unacceptable	2 = 2%	4 = 4%	6 = 6%	12 = 13%
No opinion	60 = 65%	64 = 69%	59 = 64%	67 = 72%
Acceptable	31 = 33%	25 = 27%	28 = 30%	14 = 15%
Brochure				
Unacceptable	9 = 10%	7 = 7%	7 = 7%	16 = 17%
No opinion	51 = 55%	52 = 56%	51 = 55%	58 = 62%
Acceptable	33 = 35%	34 = 37%	35 = 38%	19 = 21%
Film				
Unacceptable	8 = 9%	7 = 7%	8 = 9%	13 = 14%
No opinion	60 = 64%	60 = 65%	62 = 66%	68 = 73%
Acceptable	25 = 27%	26 = 28%	23 = 25%	12 = 13%

(N = 93)

The majority of the respondents offered no opinion regarding the materials. The highest number of unacceptable responses was to the question of "Were the materials interesting?" Although 13 - 17 percent of the respondents answered no, 15 - 21 percent answered yes. The brochure received the highest overall rating with one third of the respondents describing it as comprehensive, informative, and objective, if not interesting.

Table 2b. MATERIALS
Responses--Los Angeles Only

	Comprehensive		Informative		Objective		Interesting	
	#	%	#	%	#	%	#	%
Flip Chart								
Unacceptable	0	0%	1	5%	1	5%	2	10%
No opinion	17	81%	11	52%	9	43%	16	76%
Acceptable	4	19%	9	43%	11	52%	3	14%
Script								
Unacceptable	0	0%	0	0%	0	0%	2	10%
No opinion	13	62%	11	52%	7	33%	15	71%
Acceptable	8	38%	10	48%	15	67%	4	19%
Brochure								
Unacceptable	1	5%	1	5%	2	10%	3	14%
No opinion	9	43%	9	43%	7	33%	12	57%
Acceptable	11	52%	11	52%	12	57%	6	29%
Film								
Unacceptable	0	0%	0	0%	2	10%	2	10%
No opinion	10	48%	9	53%	9	43%	13	62%
Acceptable	11	52%	12	57%	10	48%	6	28%

(N = 21)

3. If any of the following methods are implemented, at what point in the eligibility process should it be presented? Indicate your opinion of each, using the following scale:

0 = unacceptable* 1 = no opinion 2 = acceptable

	County Worker	HMO Rep	PHRED Rep	Film	Brochure
In Conjunction With Screening Interview (If Applicable)					
Immediately After EW Interview					
During EW Homecall (If Applicable)					
Other** (See Below)					

*Please explain "unacceptable" responses.

**A Medi-Cal presentation scheduled at a time other than the EW interview but prior to approval of the application. For example, presentations could be scheduled on a daily basis at 9:00, 11:00, 1:00, and 3:00 o'clock. (This method was not tested in the demonstrations.)

Table 3a. ORDER IN PROCESS
Responses--All Counties

	County Worker # %	HMO Rep # %	PHRED Rep # %	Film # %	Brochure # %
In Conjunction with Screening Interview					
Unacceptable	50=54%	27=29%	25=27%	25=27%	16=17%
No opinion	34=36%	50=54%	52=56%	51=55%	47=51%
Acceptable	9=10%	16=17%	16=17%	17=18%	30=32%
Immediately After EW Interview					
Unacceptable	44=47%	22=24%	17=18%	21=23%	18=19%
No opinion	31=33%	34=36%	41=44%	41=44%	38=41%
Acceptable	18=20%	37=40%	35=38%	31=33%	37=40%
During EW Home Call					
Unacceptable	42=45%	29=31%	30=32%	34=36%	31=33%
No opinion	40=43%	51=55%	49=53%	49=53%	45=49%
Acceptable	11=12%	13=14%	14=15%	10=11%	17=18%
Other					
Unacceptable	34=36%	12=13%	11=12%	11=12%	8= 9%
No opinion	48=52%	61=65%	59=63%	60=64%	62=66%
Acceptable	11=12%	20=22%	23=25%	22=24%	23=25%

(N = 93)

All methods, other than the county worker method, were found to be acceptable immediately after the eligibility worker interview by 38 - 40 percent of the respondents. The highest "unacceptable" response was 54 percent for the county worker method in conjunction with the screening interview.

Table 3b. ORDER IN PROCESS
Response--Los Angeles Only

	County Worker		Film		HMO Rep		PHRED Rep		Brochure	
	#	%	#	%	#	%	#	%	#	%
In conjuction with screening interview										
Unacceptable	12	57%	4	19%	3	14%	2	10%	1	5%
No opinion	7	33%	15	71%	14	67%	13	62%	13	62%
Acceptable	2	10%	2	10%	4	19%	6	28%	7	33%
Immediately after EW interview										
Unacceptable	6	28%	3	14%	2	10%	0	0%	2	10%
No opinion	12	57%	11	52%	10	48%	9	43%	10	48%
Acceptable	3	14%	7	33%	0	42%	12	57%	9	42%
During EW Home Call										
Unacceptable	11	52%	6	28%	5	24%	5	24%	11	52%
No opinion	7	33%	11	52%	12	57%	11	52%	11	52%
Acceptable	3	14%	4	19%	4	19%	11	52%	6	29%
Other										
Unacceptable	10	48%	3	14%	2	10	3	14%	2	10%
No opinion	9	42%	13	62%	16	76%	14	67%	13	62%
Acceptable	2	10%	5	24%	3	14%	4	19%	6	28%

(N = 21)

4. If one of the methods is implemented, when would be the appropriate time to present it to the client? Indicate your opinion of each, using the following scale:

0 = unacceptable 1 = no opinion 2 = acceptable

	During Intake Process	During Redetermination Process	Other (Explain)
PHRED Representative			
HMO Representative			
County Worker			
Film			
Brochure			

Other: _____

_____

*Please explain "unacceptable" responses.

Table 4a. SETTING
Responses--All Counties

Method:	Intake #	Intake %	Redetermination #	Redetermination %	Other* #	Other* %
PHRED Representative						
Unacceptable	19	20%	15	16%	--	
No Opinion	34	37%	49	53%	90	97%
Acceptable	40	43%	29	31%	3	3%
HMO Representative						
Unacceptable	25	27%	18	19%	--	
No Opinion	31	33%	46	50%	90	97%
Acceptable	37	40%	29	31%	3	3%
County Worker						
Unacceptable	43	46%	36	39%	--	
No Opinion	35	38%	47	50%	90	97%
Acceptable	15	16%	10	11%	3	3%
Film						
Unacceptable	22	24%	19	20%	--	
No Opinion	43	46%	52	56%	90	97%
Acceptable	28	30%	22	24%	3	3%
Brochure						
Unacceptable	13	14%	14	15%	--	
No Opinion	37	40%	50	54%	90	97%
Acceptable	43	46%	29	31%	3	3%

(N = 93)

* Other = Several respondents suggested that the client be referred to the Medi-Cal presentation by client request only.

The intake setting was generally more acceptable than the redetermination setting for all methods.

Table 4b. SETTING
Responses--Los Angeles Only

Method:	Intake #	Intake %	Redetermination #	Redetermination %	Other
PHRED Representative					
Unacceptable	1	4%	0	0%	
No opinion	9	43%	14	67%	21 = 100%
Acceptable	11	53%	7	33%	
HMO Representative					
Unacceptable	3	14%	2	10%	
No opinion	9	43%	13	62%	21 = 100%
Acceptable	9	43%	6	28%	
County Worker					
Unacceptable	8	38%	7	33%	
No opinion	8	38%	13	63%	21 = 100%
Acceptable	5	24%	1	4%	
Film					
Unacceptable	0	0%	0	0%	
No opinion	12	57%	15	71%	21 = 100%
Acceptable	9	43%	6	29%	
Brochure					
Unacceptable	1	4%	2	10%	
No opinion	10	48%	13	61%	21 = 100%
Acceptable	10	48%	6	29%	

(N = 21)

5. I learned new information about Medi-Cal from participating in the Project. _____

Rate statement 5 using the following scale:

All County Response

0 = unacceptable 1 = no opinion 2 = acceptable

Overall, 27 percent (25 respondents) of the county workers stated that they did not learn new information. Sixty-one percent (57 respondents) stated that they had no opinion, and twelve percent

(11 respondents) stated that they learned new information from participating in the Project.

Los Angeles Only

Unacceptable	3 = 10%
No opinion	10 = 33%
Acceptable	8 = 38%

6. I think the clients were given valuable information about the Medi-Cal Program. _____

All County Response

0 = unacceptable 1 = no opinion 2 = acceptable

Overall, 17 percent (16 respondents) of the county workers stated that they thought their clients did not learn new information. Fifty-six percent (52 respondents) stated that they had no opinion, and twenty-seven (25 respondents) thought that their clients had learned new information from participating in the project.

Los Angeles Only

Unacceptable	2 = 10%
No opinion	7 = 33%
Acceptable	12 = 57%

7. Whom do you think should be responsible for explaining the Medi-Cal program to clients? _____

Table 7a. WHO SHOULD INFORM THE CLIENT
Responses

	All Counties		Contra Costa		Los Angeles	
	#	%	#	%	#	%
Opinion	81 =	87%	26 =	100%	21 =	100%
No Opinion	12 =	13%	0 =	0	0 =	0
Total	93 =	100%	26 =	100%	21 =	100%

Table 7b. BREAKDOWN OF OPINIONS ON RESPONSIBILITY QUESTION

	All Counties		Contra Costa		Los Angeles	
	#	%	#	%	#	%
Eligibility Worker	15	19%	3	13%	1	5%
Medi-Cal Worker	12	15%	3	10%	1	5%
HMO Representative	11	14%	10	42%	0	0
Brochure Only	9	11%	1	3%	1	5%
Special Medi-Cal Rep	10	12%	1	3%	0	0
PHRED (State) Rep	16	20%	6	23%	16	75%
County Worker (Not EW or County PHP Rep)	4	5%	0	0	0	0
Definitely Not an EW	1	1%	0	0	1	5%
EW Should Present "Stickers,"* HMO Reps should present HMOs	2	1%	2	6%	0	0
No One	1	0	0	0	1	5%
	81	100%	26	100%	21	100%

*Fee-for-service Medi-Cal cards are referred to as "stickers" because of their removable labels.

The majority of the respondents answered the above question. The responses varied with the highest number agreeing that it is the state's responsibility to inform the clients of their Medi-Cal choice. Although 19 percent thought it is the EW's responsibility, most added that it was also impractical in the current county setting. An additional total of 26 respondents (32 percent) suggested that a specialized county worker (Medi-Cal worker, special Medi-Cal representative or county worker) should inform the client.

Fourteen percent of all the respondents indicated that it is the responsibility of the HMO representative to present the dual choice. This figure represents 42 percent of the Contra Costa employees and 0 percent of the Los Angeles County employees. HMO representatives currently present the dual choice in Contra Costa where the HMO is operated by the county itself; whereas in Los Angeles, the county's experience with the marketing activities of the health plans has been limited to dealing with complaints and problems generated by door-to-door solicitation.

8. Which of the methods, if implemented, would least interfere with your present duties?

Table 8a. METHOD WITH LEAST INTERFERENCE
Breakdown of Responses

	All Counties	Contra Costa	Los Angeles
	# %	# %	# %
Opinion	71 = 76%	26 = 100%	14 = 67%
No Opinion	20 = 24%	0 = 0	7 = 33%
Total	93 = 100%	26 = 100%	21 = 100%

Table 8b. METHOD WITH LEAST INTERFERENCE
Responses With Opinions

	All Counties	Contra Costa	Los Angeles
	# %	# %	# %
Brochure	20 = 28%	4 = 15%	4 = 29%
Film	4 = 6%	0 = 0	3 = 21%
PHRED Rep	15 = 21%	2 = 8%	3 = 21%
HMO Rep	20 = 28%	18 = 69%	0 = 0
EW	0 = 0	0 = 0	0 = 0
Any method except EW	8 = 11%	2 = 8%	1 = 7%
All methods unreasonably interfere	4 = 6%	0 0	3 = 21%
	71 = 100%	26 = 100%	14 = 99%

The brochure and HMO representative method were the overall favorites. However, the HMO method represents a 69 percent rate for Contra Costa and 0 percent for Los Angeles. As in question 7, the Contra Costa employees are comparing the method currently utilized with something that they view as a "new way." The brochure method and the HMO Representative Method were chosen by 28 percent of the respondents to be the methods with the least interference. Los Angeles respondents expressed 29 percent preference for the brochure method and none for the HMO Representative Method. It is interesting to note that 11 percent of the respondents stated that 11 percent of the respondents stated that it does not matter which

method is used to present dual choice as long as it does not involve the EWs. Also, 6 percent of the respondents stated that all of the methods "unreasonably" would interfere with their present duties. The reason most often given was that, regardless of the method, the clients always ask their EWs for clarification, confirmation, and/or validation and the EWs do not have the time to incorporate this into their schedules.

9. Which of the methods, if implemented, would most interfere with your present duties? _____
Why? _____

Table 9a. METHOD WITH MOST INTERFERENCE
Responses

	All Counties	Contra Costa	Los Angeles
	# %	# %	# %
Opinion	69 = 74%	26 = 100%	16 = 76%
No Opinion	24 = 26%	= 0	5 = 24%
Total	93 = 100%	26 = 100%	21 = 100%

Table 9b. MOST DISRUPTIVE METHOD
Responses With Opinions

	All Counties	Contra Costa	Los Angeles
	# %	# %	# %
Brochure	1 = 1%	0 = 0	0 = 0
Film	5 = 7%	0 = 0	4 = 25%
PHRED Representative	6 = 9%	1 = 4%	1 = 6%
HMO Representative	0 = 0	0 = 0	0 = 0
EW	50 = 72%	24 = 92%	7 = 44%
All Methods	7 = 11%	1 = 4%	4 = 25%
	69 = 100%	26 = 100%	16 = 100%

The answer given most often was that EWs do not have time to present dual-choice information. The methods which require an "outsider", such as a state worker, create interference because the county staff has to explain their procedure and incorporate the outsider's schedule and procedure into their schedules. Thus, 72

percent of the employees who answered the above question stated that the Eligibility Worker Method would most interefere with their present duties. This figure represents 92 percent of the Contra Costa employees (with a 100 percent response rate) and 44 percent of the Los Angeles employees (with a 76 percent response rate). The brochure method (0 percent) and the HMO representative method (1 percent) are consistent with the answers given in question 8.

10. Which method would be the least acceptable to you? _____

Why? _____

Table 10a. METHOD LEAST ACCEPTABLE
Responses

	All Counties	Contra Costa	Los Angeles
	# Percent	# Percent	# Percent
Opinion	64 = 69%	26 = 100%	11 = 53%
No Opinion	29 = 31%	= 0	10 = 47%
Total	93 = 100%	26 = 100%	21 = 100%

Table 10b. METHOD LEAST ACCEPTABLE
Responses With Opinions

	All Counties	Contra Costa	Los Angeles
	# %	# %	# %
Brochure	2 = 3%	1 = 4%	1 = 9%
Film	3 = 5%	0 = 0%	0 = 0%
PHRED Representative	4 = 6%	0 = 0%	0 = 0%
HMO Representative	5 = 8%	0 = 0%	0 = 0%
EW	50 = 78%	25 = 96%	10 = 91%
	64 = 100%	26 = 100%	11 = 100%

The answer most often given was "EWs do not have the time to present the Medi-Cal information." Contra Costa (96 percent) and Los Angeles County (91 percent) agreed with the 78 percent overall total of employees indicating that the EW method would be the least acceptable method.

11. Which method would be most acceptable to you? _____
Why? _____

Table 11a. METHOD WITH MOST ACCEPTANCE
Responses

	All Counties		Contra Costa		Los Angeles	
	#	Percent	#	Percent	#	Percent
Opinion	65	= 70%	26	= 100%	15	= 70%
No Opinion	28	= 30%		= 0%	6	= 30%
Total	93	= 100%	26	= 100%	21	= 100%

Table 11b. METHOD WITH MOST ACCEPTANCE
Responses with opinions

	All Counties		Contra Costa		Los Angeles	
	#	%	#	%	#	%
Brochure	22	= 34%	4	= 14%	6	= 41%
Film	6	= 9%	1	= 3%	5	= 33%
PHRED Representative	13	= 20%	4	= 17%	2	= 13%
HMO Representative	17	= 26%	16	= 63%	0	= 0%
EW	2	= 3%	1	= 3%	2	= 13%*
Anything but EW	5	= 8%	0	= 0%	0	= 0%
	65	= 100%	26	= 100%	15	= 100%

*The respondents specified a "special" EW.

As noted in the previous question, the EW method received the lowest percentage of positive responses. The method most acceptable overall is the brochure method with 34 percent of the overall and 41 percent of the Los Angeles respondents choosing this method. The HMO representative method ranks second overall with 63 percent of all the Contra Costa respondents ranking it as the most acceptable method. Los Angeles County respondents disagreed, ranking it 0.

12. If the method you suggest in item 11 is implemented, would you recommend any procedural changes? No ___ Yes ___ What changes?

_____

_____

The preponderance of respondents provided no answer to this question. Of those who did respond, most misinterpreted the question, suggesting that the dual choice be placed either at intake or redetermination.

Now is your chance to give us your general comments on the dual-choice program and the PHRED Project.

Comments: _____

_____

_____

_____

Most respondents provided no comments. Of those who addressed the question, most felt that the PHRED Project had been an unwelcome intrusion upon their work setting.

II. Health Plan Acceptability Survey

The health plans which participated in the PHRED Project marketing/enrollment demonstrations were asked to complete a survey to determine the acceptability of the methods to HMOs. Of the nine which had originally participated, two were no longer contracting with the State to provide services to Medi-Cal clients at the time of the survey. Four of the remaining seven plans responded.

In summary, the plans felt that each method had certain advantages and disadvantages although the use of a plan representative was favored, either alone or in conjunction with other methods. The survey instrument may be found on page _____; each question is listed below, followed by the plans' responses.

Questions and Responses

1. What were the advantages which you saw in each of the following enrollment methods?

   A. Mailing:

      Responses to the mailing method varied. One plan saw no discernible advantage to the mailing method employed by PHRED. Three plans noted that the mailing did provide a large number of clients who were already eligible to enroll in a plan with information about the plans. One of those plans further stated that this method at least shows the recipient that the Department of Health Services has a positive view of the HMO Program.

   B. Welfare Office Presentations:

      1. Brochure Only Method:

         Two plans responded that the Brochure Only Method was not useful, or at best, adequate. The only perceived advantage was that it provided information about HMOs to those clients who could and would read the materials.

      2. Film Method:

         The health plans universally agreed that the film method provided information about the HMO and fee-for-service delivery systems to clients. One plan added, however, that the film could not stand alone as a method. Someone would need to be present to respond to specific questions about the alternatives.

3. County Representative Method:

The county representative method was viewed as a useful way to bring more credibility to the HMO program as well the means to a universal choice-mailing situation. One plan expressed the opinion that this method was more personal (and, therefore, better) than the brochure or film methods.

4. State Representative Method:

The state representative method gathered a variety of responses from the four health plans. One felt that the method had no advantages. Another stated that, like the county worker method, the state representative method was more personal than the film or brochure methods. One plan stated that a neutral presentation was given to the client which allowed the choice to be made. Another stated that use of the state representative method showed that the Department of Health Services was concerned about the availability of health care delivery.

5. Plan Representative Method:

The plan representative method was perceived by the survey respondents to be the most advantageous. Reasons cited included the personal approach of a one-on-one encounter, the increase in credibility for the HMO program, and the belief that plan representatives understand the plan specifics better and more accurately than either a county worker or a state representative.

2. What were the disadvantages of each method?

A. Brochure Only Method:

Two major disadvantages to the Brochure Only Method were cited by the survey respondents:

1. Clients often cannot or will not read materials.

2. The brochure was not descriptive and detailed enough to compare and decide on an alternative without verbal assistance. One plan also felt that the brochure alone is not enough of a motivator to trigger a choice.

B. Film Method:

The film method did not present enough information and detail to allow an informed choice, according to the survey respondents. One plan stated that the film was not geared to motivating a choice for the HMO delivery system.

C. County Representative Method:

Two respondents felt that county workers were negatively biased against the HMO delivery system. One respondent stated that the county worker could not give as comprehensive a presentation as the plan representative could. Another plan felt that problems with county workers regarding HMO activities were controlled under the PHRED Project but could become evident in the future as county workers were reassigned or added.

D. State Representative Method:

Two plans stated that the state representative did not present information in as comprehensive a fashion as the plan representative. One plan felt that a disadvantage to the state representative method was that state employees had not been trained in marketing sales techniques. Another felt that the neutrality of the state representative afforded much less than a recommendation to try the HMO delivery system.

E. Plan Representative Method:

Two plans felt constricted by the research design. (Plan representatives were not allowed to proceed with a more comprehensive presentation than allowed for by the demonstrations.) One plan stated that a disadvantage was the inability of the plan representative to work on a pay-incentive basis. (Plans were not allowed to pay commissions for enrollments generated by their representatives during the welfare office demonstrations.) Another plan had no problems with this method.

3. If you had to pick one or a combination of these methods as a primary enrollment program, which would you choose and why?

Each survey respondent presented a different answer to this question.

A. Use the plan representative method with the film method.

B. Have a county representative provide an overall presentation and a plan representative provide more specific information.

C. Have a county representative show the film followed by a plan representative to provide more specific information.

D. Use a film produced by the plan in conjunction with the state and discussed by health plan representatives.

4. Which method(s) would you recommend not using and why?

One plan had no response to this question. One plan argued that the brochure and the film alone should not be used because they did not enable the recipient to ask questions. Another plan stated that the mailing and brochure methods should not be used because the materials are not read and response is low. Finally, one plan stated that county representatives are generally not interested, trained, or desirous of being involved in making a presentation involving choice to a recipient. The plan further stated that the county representatives' biases provide a strong negative base for presentation of alternatives to the traditional Medi-Cal systems.

5. Are there other methods which you would like to see the Department try?

Plans supplied a number of alternative marketing methods in response to this question.*

A. Plan representative could provide a comprehensive enrollment presentation in the welfare office followed by a state or county verification.

B. Assignment of recipients to HMOs.

C. Re-establish the two-service per month limitation on the fee-for-service delivery system.

*Additionally, one plan suggested that the Department of Health Services require a six-month lock-in for clients choosing an HMO.

6. Do you have any other comments on the PHRED marketing/enrollment demonstrations?

Comments provided by the survey respondents were as follows:

A. One plan had no comment.

B. One plan felt that the Department of Health Services should continue to explore alternative marketing strategies.

C. One plan felt that telephone verifications of new enrollments is too costly and time-consuming to justify the results obtained.

D. One plan felt that the HMOs should have had more input to development of the PHRED Project film.

(County) ACCEPTABILITY SURVEY

County Position: _____
County Office: _____
County: _____

Rate each method, using the definitions below and the following scale:

0 = unacceptable 1 = no opinion 2 = acceptable

1. Method Evaluation

	Time	Comprehension	Objective	Practical
PHRED Representative				
HMO Representative				
County Worker				
Film				
Brochure				

Definitions

Time--Did this method take a reasonable amount of client and EW time?

Comprehension--Did the clients seem to understand the dual choice process? Did the clients ask their EW to re-explain the dual choice?

Objective--Did this method appear unbiased in presenting the two kinds of Medi-Cal?

Practical--If this method is implemented, would it be practical in your office? (Please rate only the method of the presentation using a simple choice form, rather than the paperwork used by the Project.)

2. How would you rate the demonstration materials, using the definitions below and the following scale:

0 = unacceptable 1 = no opinion 2 = acceptable

	Comprehensive	Informative	Objective	Interesting
Flip Chart				
Script (Presentation)				
Brochure				
Film				

Definitions

Comprehensive--Was it easy to understand?

Informative--Did it present useful information?

Objective--Was it unbiased in presenting the two kinds of Medi-Cal?

Interesting--Was it interesting to the clients?

3. If any of the following methods are implemented, at what point in the eligibility process should it be presented? Indicate your opinion of each, using the following scale:

0 = unacceptable* 1 = no opinion 2 = acceptable

Methods:	County Worker	HMO Rep	PHRED Rep	Film	Brochure
In Conjunction With Screening Interview (If Applicable)					
Immediately After EW Interview					
During EW Homecall (If Applicable)					
Other** (See Below)					

**A Medi-Cal presentation scheduled at a time other than the EW interview but prior to approval of the application. For example, presentations could be scheduled on a daily basis at 9:00, 11:00, 1:00, and 3:00 o'clock.

*Please explain "unacceptable" responses.

4. If one of the methods is implemented, when would be the appropriate time to present it to the client? Indicate your opinion of each, using the following scale:

0 = unacceptable* 1 = no opinion 2 = acceptable

	During Intake Process	During Redetermination Process	Other (Explain)
PHRED Representative			
HMO Representative			
County Worker			
Film			
Brochure			

*Please explain "unacceptable" responses.

Other: _____

Rate statements 5 and 6 below, using the following scale:

0 = unacceptable* 1 = no opinion 2 = acceptable

5. I learned new information about Medi-Cal from participating in the Project. _____

6. I think the clients were given valuable information about the Medi-Cal Program. _____

*Please explain "unacceptable" responses.

_____

_____

_____

******** ********

7. Whom do you think should be responsible for explaining the Medi-Cal program to clients? _____

_____

_____

8. Which of the methods, if implemented, would least interfere with your present duties? _____

9. Which of the methods, if implemented, would most interfere with your present duties? _____
Why? _____

_____

10. Which method would be the least acceptable to you? _____
Why? _____

_____

11. Which method would be most acceptable to you? _____
Why? _____

_____

12. If the method you suggest in item 11 is implemented, would you recommend any procedural changes? No _____ Yes _____ What changes? _____

_____

_____

Now is your chance to give us your general comments on the dual choice program and the PHRED Project.

Comments: _____

1. What were the advantages which you saw in each of the following enrollment methods?

   A. Mailing _____

   B. Welfare Office Presentations:

      1. Brochure Only Method _____

      2. Film Method _____

      3. County Representative Method _____

      4. State Representative Method _____

      5. Plan Representative Method _____

2. What were the disadvantages of each method?

A. Brochure Only Method _____

B. Film Method _____

C. County Representative Method _____

D. State Representative Method _____

E. Plan Representative Method _____

3. If you had to pick one or a combination of these methods as a primary enrollment program, which would you choose and why?

4. Which method(s) would recommend not using and why?

5. Are there other methods which you would like to see the Department try?

6. Do you have any other comments on the PHRED marketing/enrollment demonstrations?

APPENDIX K

Plan Agreement to Participate,
Performance Specifications

STATE OF CALIFORNIA — HEALTH AND WELFARE AGENCY

EDMUND G. BROWN JR., *Governor*

DEPARTMENT OF HEALTH SERVICES
~~1616 "I" STREET~~ 455 Capitol Mall, Room 250
SACRAMENTO, CA 95814
(916) 322-4616

10 May 1979

Elizabeth Lamkin
CompreCare
3850 Wilshire Boulevard
Los Angeles, CA 90010

Dear Ms. Lamkin:

This letter confirms agreements reached with your plan regarding the participation of CompreCare in the PHRED Project Membership Studies demonstrations. Based on those discussions we respectively agree to the following provisions:

General Provisions

A. Nothing in this agreement requires either party to reimburse the other for performing under the terms of the agreement and reimbursement shall not take place.

B. Performance under the terms of this agreement does not relieve CompreCare of its total responsibility for the conduct of all marketing activities in accordance with Title 22, CAC Section 53400 and the terms of its contract with the Department of Health Services contract #78-62993, and Section 1361 of the Health and Safety Code.

C. This agreement is entered into to comply with the provisions of Welfare and Institutions Code Section 14411(a)(1) and (3).

CompreCare agrees to perform the following:

A. Report required presentation results and cost data in formats specified by the Department and attached to this agreement, and retain such data for no less than one year following the termination of this agreement.

B. Assign qualified marketing representative(s) as defined in Section 53402, Title 22, California Administrative Code and Article VIII(I) of the contract with the Department of Health Services to participate for at least a 10-week period as specified by the Department in the demonstration project at the designated demonstration site. During participation in the demonstration, reimbursement for such representative(s) shall not be based on numbers of eligible Medi-Cal beneficiaries enrolled through the demonstration.

C. Adhere strictly to the research design of the demonstration as specified by the Department.

D. Provide supervision for CompreCare representative(s) participating in demonstrations, i.e., ensure punctuality, provide replacement if representative(s) become unavailable, etc.

E. Release CompreCare representative(s) and their supervisor(s) for training as required by the Department to meet the terms of this agreement.

F. Use written materials developed by the Department for the demonstrations at the demonstration site.

The California Department of Health Services agrees to perform the following:

A. Describe all data required and provide all reporting formats, timetables, forms and procedures.

B. Develop and provide a time schedule for each demonstration within the Project prior to the beginning date of the Project.

C. Provide training to CompreCare representative(s) participating in the demonstrations.

D. Obtain required space in demonstration sites for said CompreCare representative(s).

E. Monitor the performance of the demonstration.

F. Provide technical assistance to CompreCare during the term of the project to ensure adherence to research procedures.

G. Provide referrals from mailing and welfare office demonstrations for plan follow-up.

H. Provide CompreCare with a final report on the outcome of the project.

I have also attached a schedule and a listing of the ZIP Codes served by the demonstration site welfare office. Please sign on the line below and return this original copy to me. You may keep the second copy for your records.

Sincerely,

John M. Kennetty for

Elizabeth W. Owen
Research Specialist
Membership Studies
PHRED Project

_____
CompreCare

_____
(Date)

Marketing Costs--Report for MAFED Administration

1. Direct Costs

	Total % Time	$ Cost
A. Direct Labor (salary and commission)		
1. Enroller #1		
Enroller #2		
Enroller #3		
		$
2. Clerical		$
3. Verification Staff		$
4. Supervisor		$
5. Marketing Manager		$
B. Payroll Additives (% of DL)		$
C. Mileage		$
D. Other Direct Costs (specify)		
		$

Indirect Costs (give total expense for period)

A. Materials (printed)	$
B. Advertising Costs	$
C. Tapes for Verifications	$
D. Other Supplies	$
E. Telephone	$
F. Equipment	$
G. Space (rent)	$
H. Utilities	$
I. Depreciation	$
J. Other (specify)	
	$

State of California—Health and Welfare Agency

PRESENTATION RESULTS REPORT

Department of Health Services

Name of Rep: Name of Plan: Method: Date:

(1) a. Street b. City	(2) Street Number	(3) Apt. Number	(4) Person Home? Yes/No	(5) a. Name of Person Contacted b. Medi-Cal Number	(6) Eligible for PHP Yes/No	(7) Name of PHP If Enrolled	(8) Presentation Made Yes/No	(9) Refusal of Presentation Yes/No/NA	(10) Number of Enrollments	(11) Number of Persons in Family	(12) Time Started (Ex: 12:15 P.M.)	(13) Time Ended (Ex: 12:30 P.M.)	(14) Time in Transit (Ex: 010 Min.)	(15) a. Phone Number (If Available b. Notes (Explain Nos. in 8 & 9 and Discrepancy in 10 & 11)
a.				a.										a.
b.				b.										b.
a.				a.										a.
b.				b.										b.
a.				a.										a.
b.				b.										b.
a.				a.										a.
b.				b.										b.
a.				a.										a.
b.				b.										b.
a.				a.										a.
b.				b.										b.

...of Californ... Health and Welfare Agency

Departme... Health Services

REFERRAL INFORMATION FORM (RIF)

Appendix D: Data Collection Forms
Item 11
Referral Information Form

1. Referral Number:

2. Referral's Name: (Last, First, Middle)

3. Referral's Medi-Cal Number:

4A. Referral's Address (House Number, Street or Road)

(City) (County)

4B. Zip

5. Referral's Phone Number:

6. Date Sent to Plan:

7. Date RIF returned to PHRED:

Name of Plan _____

To Plan: The above person has indicated that he/she wishes to enroll after receiving a presentation and/or information in the local Social Services Office.

8. Please contact this person within: (Days)

9. And return this form to PHRED by: Month Day Year

DESCRIBE THE FIRST CONTACT:

10. Date: (Month, Day, Year)

11. Method of Contact:
1) ☐ Phone 2) ☐ Mail
3) ☐ Home 4) ☐ Walk-in

12. Results of first contact:
1) ☐ Verified Enrollee 2) ☐ Enrolled Other Plan
3) ☐ No Contact 4) ☐ Decision Pending
5) ☐ Stay on Regular Medi-Cal 6) ☐ Other: _____

13. How many persons enrolled? (Enter number)

14. Does this represent the referral's total family?
1) ☐ Yes 2) ☐ No

15. How many not enrolled?

16. Explain nonenrolling family members (if any) _____

17. How many attempts were made before the individual was contacted? (Enter number)

IF MORE THAN ONE CONTACT, DESCRIBE THE LAST:

18. Date: (Month, Day, Year)

19. Method of Contact:
1) ☐ Phone 2) ☐ Mail
3) ☐ Home 4) ☐ Walk-in

20. Results of Last Contact:
1) ☐ Verified Enrollee 2) ☐ Enrolled Other Plan
3) ☐ No Contact 4) ☐ Decision Pending
5) ☐ Stay on Regular Medi-Cal 6) ☐ Other: _____

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